Hampshire County Council

NOTICE OF MEETING

Meeting	Health and Adult Social Care Select Committee
Date and Time	Tuesday, 14th May, 2019 at 10.00 am
Place	Ashburton Hall - HCC
Enquiries to	members.services@hants.gov.uk

John Coughlan CBE
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting may be recorded and broadcast live on the County Council's website. The meeting may also be recorded and broadcast by the press and members of the public – please see the Filming Protocol available on the County Council's website.

AGENDA

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Personal Interest in a matter being considered at the meeting should consider, having regard to Part 5, Paragraph 4 of the Code, whether such interest should be declared, and having regard to Part 5, Paragraph 5 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 12)

To confirm the minutes of the previous meeting

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES (Pages 13 - 86)

To consider a report of the Director of Transformation and Governance on issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

a. Hampshire Hospitals Foundation Trust - CQC Inspection Update
b. Portsmouth Hospitals NHS Trust– Update following CQC focused inspection of Emergency Department in February 2019

7. PROPOSALS TO VARY SERVICES (Pages 87 - 102)

To consider the report of the Director of Transformation and Governance on proposals from the NHS or providers of health services to vary or develop health services in the area of the Committee.

Items for Monitoring

a) Portsmouth Hospitals Trust: Spinal Surgery Service Implementation update

b) Southern Health NHS Foundation Trust: Update on Temporary Closure of Older People's Mental Health Ward (Beaulieu)

Items for Information

a) Southern Health NHS Foundation Trust: Planned Changes to West Hampshire Learning Disability Service

8. INTEGRATED INTERMEDIATE CARE (Pages 103 - 110)

To receive a report on the background and the latest position with regard to the creation of an integrated Intermediate Care service to operate across the whole of Hampshire.

9. HEALTH AND WELLBEING STRATEGY 2019-2024 (Pages 111 - 134)

To receive a report on the development of the Hampshire Health and Wellbeing Board's new strategy, A Strategy for the Health and Wellbeing of Hampshire 2019–2024, and the business plan which will support its delivery.

10. WORK PROGRAMME (Pages 135 - 146)

To consider and approve the Health and Adult Social Care Select Committee Work Programme.

ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. If you have any particular requirements, for example if you require wheelchair access, please contact members.services@hants.gov.uk for assistance.

County Councillors attending as appointed members of this Committee or by virtue of Standing Order 18.5; or with the concurrence of the Chairman in connection with their duties as members of the Council or as a local County Councillor qualify for travelling expenses.

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AT A MEETING of the Health and Adult Social Care Select Committee of HAMPSHIRE COUNTY COUNCIL held at the castle, Winchester on Tuesday, 2nd April, 2019

Chairman:
p Councillor Roger Huxstep

Vice Chairman:
p Councillor David Keast

a Councillor Martin Boiles
p Councillor Ann Briggs
a Councillor Adam Carew
p Councillor Fran Carpenter
a Councillor Tonia Craig
p Councillor Alan Dowden
p Councillor Steve Forster
a Councillor Jane Frankum
p Councillor David Harrison
p Councillor Marge Harvey
p Councillor Pal Hayre
p Councillor Neville Penman
p Councillor Mike Thornton
p Councillor Jan Warwick

Co-opted members
a Councillor Tina Campbell
p Councillor Alison Finlay
a Councillor Trevor Cartwright

Also present with the agreement of the Chairman: Councillor Liz Fairhurst, Executive Member for Adult Social Care and Health, and Councillor Patricia Stallard, Executive Member for Public Health

120. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Martin Boiles. Councillor Lance Quantrill, as the Conservative standing deputy, was in attendance in his place.

Apologies were also received from Councillor Tonia Craig. Councillor Dominic Hiscock, as the Liberal Democrat standing deputy, was in attendance in her place.

Apologies were also received from Councillor Jane Frankum and co-opted member Councillor Trevor Cartwright.

121. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a Non-Pecuniary interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, considered whether it was appropriate to leave the

meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

Councillor Jan Warwick declared a personal non pecuniary interest that she had been an expert advisor to the Care Quality Commission, however not in Hampshire.

122. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 16 January 2019 and the Minutes of the Call In meeting held on 14 March 2019 were confirmed as a correct record and signed by the Chairman.

123. DEPUTATIONS

The Committee did not receive any deputations.

124. CHAIRMAN'S ANNOUNCEMENTS

The Chairman made the following announcement:

Southern Health Restructure
In December 2018, Southern Health consulted stakeholders including the HASC seeking feedback on options to re-shape their operational organisational structure. The Chairman had responded to the consultation on behalf of the HASC. Southern Health had since shared their planned structure, following that engagement. The purpose of the restructure was to enable Southern Health to align their mental health and physical health services, with the ultimate aim of delivering better, more joined-up and holistic care to people and communities across Hampshire. Following the meeting the information received from Southern Health about their restructure would be forwarded to HASC Members.

125. PROPOSALS TO VARY SERVICES

a) Hampshire Hospitals NHS Foundation Trust and West Hampshire CCG: Andover Hospital Minor Injuries Unit - Update

Representatives from the Hospital Trust and Clinical Commissioning Group presented a report providing an update on the situation with Andover Hospital Minor Injuries Unit (see report, Item 6a in the Minute Book).

Members heard that the Trust continued to hold four vacancies for Emergency Nurse Practitioners and therefore was continuing to close the Minor Injuries Unit (MIU) at 6:00pm. No increase in attendance at the Emergency Departments of the Trust's other hospitals had been seen. Nationally there was a move to consolidate services treating minor injuries into the Urgent Treatment Centre (UTC) model, therefore commissioners were looking to transition the offer at Andover hospital to an UTC. The UTC model included extended access to primary care services at evenings and weekends.

NHS England had indicated that UTC services should be available by July 2019, however it was unlikely this would be achievable in Andover. Commissioners locally were aiming for October or December 2019, although there was a chance this would slip into 2020. Commissioners were reviewing the demand from the local population, to consider whether a service open for twelve hours a day every day was necessary for the Andover population.

In response to questions, Members heard:

- It was hoped the new model would help with recruitment to staff the revised service
- Engagement had been undertaken nationally on the UTC model, and communications would be provided locally when the new UTC was ready to launch

RESOLVED

That the Committee:

a) Note the progress on transitioning the MIU at Andover War Memorial Hospital to an Urgent Treatment Centre.
b) Request a further update for the November 2019 meeting.

<u>b) Southern Health NHS Foundation Trust: Move of patients to Eastleigh & Romsey Community Mental Health Team - Update</u>

The Select Committee received a report providing an update on the move of patients who had previously been supported by the Southampton East Community Mental Health Team to come under the care of the Eastleigh and Romsey Community Mental Health Team (see report, Item 6b in the Minute Book).

RESOLVED

That the Committee:

a) Note the update on the transition
b) Request a further update be circulated to HASC Members once the transfer is complete

Change to published Agenda Order

The Chairman took the next item earlier than the published agenda, as observers were in attendance who had a particular interest in this item.

126. **WORKING GROUP PROPOSAL**

The Select Committee considered a report of the Director of Transformation and Governance, regarding a proposed Working Group to feed in to further

consideration of options relating to Orchard Close respite centre (see Item 10 in the Minute Book).

It was discussed that the first meeting of the Working Group was likely to be held in late May or June, to allow time for the Officers in Adults Health and Care to prepare. It was noted that the Terms of Reference proposed the Working Group comprise four Members and the Liberal Democrat spokesperson requested this be extended to enable more than one opposition member to take part. Councillor Harvey indicated that as Chairman of the Autism Partnership Board she would like to take part in the Working Group. It was noted that as part of the investigation of options being undertaken by officers, further engagement with stakeholders would be undertaken and the feedback received fed in to the Working Group.

RESOLVED:

To initiate a Working Group to feed in to the consideration of options relating to the future of the Orchard Close respite unit on Hayling Island, as per the proposed Terms of Reference attached to the report.

That the membership of the Working Group would be determined following the meeting, and consideration would be given to increasing the size of the group.

127. **ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES**

The Chairman took the items within Item 7 in a different order to the published agenda in order to accommodate availability of presenters:

b) Portsmouth Hospitals Trust – Update on actions following CQC report

The Medical Director from Portsmouth Hospitals Trust presented a report providing an update on action taken by the Trust in response to the areas the Care Quality Commission had identified as requiring improvement, following their inspection of the Trust's services in 2018 (see report, Item 7b in the Minute Book).

Members heard that the Trust had been implementing a detailed quality recovery plan in response to the inspection findings. A re-inspection against a section 29A notice was expected, and three section 31 notices had been removed. The Trust view was that some improvements had been made, but in some areas there was still more to do.

In response to questions, Members heard:

- It was disappointing that the caring rating had slipped from Outstanding in 2013 to Requires Improvement in 2018. The Trust was focused on promoting values and culture to improve this
- CQC had recognised that for the Well Led category it would take time for the new leadership team in place to make an impact

- The layout of the A&E area was a limitation and funding had been secured for an emergency care redevelopment project, however this would take a couple of years to reach fruition
- Pressures were being experienced due to an unprecedented increase in demand. While the system had delivered improvements to delayed transfers of care over the past year, February 2019 had seen an 18% increase in attendances compared to February 2018
- Some elective procedures had been suspended for a period in the past to help manage the emergency demand, however this had led to a backlog for some areas e.g. orthopaedics. The Trust had a recovery plan in place to deal with the backlog

RESOLVED

That the Committee:

a. Note the update on action taken by the Trust in response to the 2018 CQC inspection findings.
b. Request a further (paper only) progress update for the July 2019 meeting.
c. Request PHT attends the November 2019 meeting to provide a further update and take questions.

a) Southern Health NHS Foundation Trust – Update on actions following CQC report

Representatives from Southern Health NHS Foundation Trust provided slides to give an update on action taken by the Trust in response to the areas the Care Quality Commission had identified as requiring improvement, following their inspection of the Trust's services in 2018 (see slides, Item 7a in the Minute Book).

It was noted that the slides and the Trust's Quality Improvement Plan would be circulated to Committee Members after the meeting. Members requested that the Trust provide a further update to a future meeting and provide a written paper in advance, so that Members have a chance to review the detail.

RESOLVED

That the Committee:

a. Note the update on action taken by the Trust in response to the 2018 CQC inspection findings.

b. Request a further progress update for the July 2019 meeting.

c) Solent NHS Trust – CQC Inspection Report

Representatives from Solent NHS Trust presented a report regarding the Care Quality Commission inspection of the Trust's services undertaken in October and November 2018 (see report, Item 7c in the Minute Book).

Members heard that the Trust had been rated as Requires Improvement following their previous inspection in 2016, and were proud to report that the outcome of the 2018 inspection was an overall rating of Good, with all categories overall good or outstanding. Only two minor areas had been rated requires improvement.

RESOLVED

That the Committee:

a) Note the CQC inspection findings about Solent NHS Trust and congratulate the Trust for the number of 'Good' ratings.

b) Request an update on the two areas identified as requiring improvement, for the November 2019 meeting.

128. **CQC LOCAL SYSTEM REVIEW UPDATE**

The Select Committee received an update from the Director of Adults Health and Care at Hampshire County Council regarding progress with the actions in the action plan developed following the CQC Local System Review undertaken in 2018 (see Item 8 in the Minute Book).

Members heard that following concerted efforts by the County Council and system partners over the past year, in December 2018 there had been a 75% reduction in people waiting in hospital for social care support to enable them to leave compared to December 2017.

The Health and Wellbeing Board was responsible for overseeing the Local System Review Action Plan and had recently refreshed the Joint Health and Wellbeing Strategy for Hampshire. It was noted that the HASC had a remit to scrutinise the Health and Wellbeing Board, and this could be reflected in future work programme items.

The Chairman congratulated the Director on the reductions achieved in Delayed Transfers of Care. It was noted that as the Review and Plan covered the system not just the County Council, representatives of other partners in the system could be invited to the meeting when the HASC considered the full year performance against the action plan.

RESOLVED

That the Health and Adult Social Care Select Committee:

a) Notes this update of the Care Quality Commission's Local System Review Action Plan that has been jointly developed by Hampshire's health and care system leaders to respond to the Review's findings.
b) Receives a progress update on the Action Plan due for completion in July 2019.

129. **SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP UPDATE**

The Chairman gave a verbal update on the work of the Working Group the HASC had established in 2018 to scrutinise work taking place under the Sustainability and Transformation Partnerships covering the Hampshire population (Hampshire and Isle of Wight STP and the Frimley STP).

The Working Group had met three times across the year, and received presentations on:

- H&IOW STP: Mental Health Work Stream Update
- Frimley STP: Overall Programme Update
- H&IOW STP: New Models Of Care Update
- Frimley STP: Urgent & Emergency Care Programme Update
- HIOW STP: System Reform Proposals - Integrated Care System Developments

It was planned that the Working Group hold further meetings in 2019. In addition, the County Council's Cabinet had considered the Hampshire and Isle of Wight Sustainability and Transformation Partnership - System Reform proposals at it's meeting on 1 February 2019. The Cabinet supported the direction of travel, and requested a further update on the progress of these arrangements and in particular the progress of the systems of democratic accountability that should support these important developments.

RESOLVED

The Select Committee note the update

130. **WORK PROGRAMME**

The Director of Transformation and Governance presented the Committee's work programme (see Item 11 in the Minute Book).

The Chairman announced that for the next HASC meeting in May it was proposed to add items on the Hampshire Suicide Audit and Prevention Strategy, and the Joint Health and Wellbeing Strategy recently refreshed by the Health and Wellbeing Board.

RESOLVED:

That the Committee's work programme be approved, subject to any amendments agreed at this meeting.

Chairman,

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	14 May 2019
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 845018 **Email:** members.services@hants.gov.uk

Summary and Purpose

1. This report provides Members with information about the issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

2. Where appropriate comments have been included and copies of briefings or other information attached. Where scrutiny identifies that the issue raised for the Committee's attention will result in a variation to a health service, this topic will be considered as part of the 'Proposals to Vary Health Services' report.

3. New issues raised with the Committee, and those that are subject to on-going reporting, are set out in Table One of this report.

4. Issues covered in this report:
   a. Hampshire Hospitals Foundation Trust - CQC Inspection Update
   b. Portsmouth Hospitals NHS Trust– Update following CQC focused inspection of Emergency Department in February 2019

Recommendations

5. Summary of recommendations; the recommendations for each topic are also given under the relevant section in the table below, regarding each item being considered at this meeting:

6. *Hampshire Hospitals Foundation Trust CQC Inspection Update*

   That Members:
   a. Note the update.
   b. Request a further update for the November 2019 meeting.

7. *Portsmouth Hospitals NHS Trust– Update following CQC focused inspection of Emergency Department in February 2019*

That Members:

a. Note the findings of the focused inspection of the Emergency Department carried out at the Trust in February 2019.
b. Request progress on the issues identified in the Emergency Department be included in the CQC inspection updates already requested for the July and November 2019 meetings.

Table 1

Topic	Relevant Bodies	Action Taken	Comment
Care Quality Commission (CQC) Inspection Update - Hampshire Hospitals Foundation Trust	Hampshire Hospitals Foundation Trust CCGs and partner organisations CQC	The HASC received the latest CQC report at the November 2018 meeting. The Trust received an overall rating of Requires Improvement.	The HASC last received a paper only update at the February 2019 meeting and requested a further update for the May 2019 meeting. The Trust have provided an update, see Appendix.
Recommendations: That Members: a. Note the update. b. Request a further update for the November 2019 meeting.			
Topic	**Relevant Bodies**	**Action Taken**	**Comment**
Care Quality Commission (CQC) Focused Inspection of Emergency Department – Portsmouth Hospitals NHS Trust	Portsmouth Hospitals Trust CCGs and partner organisations CQC	The HASC has been monitoring action by the Trust since their comprehensive CQC inspection considered in September 2018 (The Trust received an overall rating of Requires Improvement.)	Since the last update the HASC received at the 2 April 2019 meeting, the CQC published a report on 16 April 2019 following a focused inspection of the Emergency Department carried out at the Trust on 25 February 2019. The Trust has provided a summary of the findings of the inspection (see appendix) and the full

Topic	Relevant Bodies	Action Taken	Comment
			CQC report is also attached.

Recommendations:

That Members:

a. Note the findings of the focused inspection of the Emergency Department carried out at the Trust in February 2019.
b. Request progress on the issues identified in the Emergency Department be included in the CQC inspection updates already requested for the July and November 2019 meetings.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Other Significant Links

Links to previous Member decisions:	
Title	Date
Issues relating to the planning provision and/or operation of health services	2 April 2019
Issues relating to the planning provision and/or operation of health services	11 February 2019
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

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Hampshire Hospitals
NHS Foundation Trust

Committee:	Health and Adult Social Services (Overview and Scrutiny) Committee
Date:	14.5.2019
Title:	Hampshire Hospitals Foundation Trust CQC Trust Wide Action Plan
Report From:	Julie Dawes Chief Nurse

Contact name: Sarah Mussett Programme Lead for Quality - sarah.mussett@hhft.nhs.uk

Executive Summary

Since our last report to the Health and Adult overview and scrutiny committee (HASC) in February, we have had two Care Quality Commission (CQC) inspections and progressed from 121 actions completed to 159 actions completed.

The CQC Winter Pressure Team completed an unannounced visit to the Emergency Department at Basingstoke on the 4th February. This was the Monday after the very heavy snowfall, which saw the department and the hospital very full and under extreme pressure. The Lead Inspector noted a sea change in the culture of the department and they saw really good examples of compassionate care and excellent communication between staff and patients. They recognised that the flow in the department had improved and the impact of the Paediatric Assessment Unit, the Rapid Assessment and Treatment bays and the Emergency Decision Unit. The Lead Inspector made a point of noting that there was nothing that they saw on the visit that required escalation or caused significant concern. We have received their final report and there are four must-do actions which have been embedded into our Trust wide action plan.

On the 9th, 10th and 11th April CQC returned to inspect the Trust against the section 29a warning notice. We are still waiting for the final report but have received a letter from CQC confirming that they had seen significant improvement across the wards in response to the section 29a and noted the hard work and commitment from staff to make the changes. They stated the staff were enthusiastic and that the teams seemed to appreciate the opportunity to demonstrate where the improvements had been made. All staff they spoke to gave positive feedback regarding the support of and for the clinical matrons. There were 3 areas of the Trust where they felt further improvements could be made and these have been included into the Trust wide action plan.

The Trust Wide action plan continues to be monitored on a weekly basis by the Chief Nurse and monthly by the Executive Team at the Executive Oversight Meeting. The action plan is moving into a business as usual document which will become part of our Trust wide quality improvement plan. We will continue to monitor closely any overdue or at risk actions.

The following actions have been competed:

- Paediatric Assessment Units and Rapid assessment and treatment bays have been opened within the emergency department at Basingstoke and imminently opening at Winchester. This has improved the Ambulabnce handover and now there is minimal delay.
- Each ward area has completed a ward estate review and a quality improvement plan
- The organisation is now at 80% compliance for medical equipment labelling and testing, the aim is to get to 90% by end of June 19
- Cleaning schedules have been reviewed and more cleaning shifts put into the Emergency department

- Workforce plans have been written which include annual review of staffing levels and review of roster compliance
- The Trust has achieved 87% compliance of staff completing mandatory training
- The Trust have carried out 25 peer reviews across all the different wards on all 3 sites. There have also been two thematic peer reviews which have specifically focused on nutrition and hydration of our patients and privacy and dignity.
- All policies have been reviewed and are up to date

A small number of actions are overdue but all are discussed weekly at our CQC meeting and held to account for delivery asap.

The themes of the overdue or at risk actions are:

Appraisal rates

We have set a challenging target of 95% of staff having an appraisal, the rate has significantly improved and is 72% but it has not met the Trust target. A new appraisal system has been introduced which will make it an easier process for staff to complete. It is therefore hoped that compliance will increase over the next couple of months.

Basic Life Support

Current Trust compliance is 79% against an 80% target. Condensed training has been introduced for non clinical areas. Greenbrain, the new training platform will make it much more accessible to do an e-learning training module and HR are also looking to introduce a smartphone application.

Paediatric competencies for out-patient areas

These are imminently going to be developed for those out-patient areas where they are not supported by Paediatric trained nurses.

Quiet and Private Areas

All Divisions need a quiet and private area to have confidential conversations with patients and relatives. For those that have identified on their ward estate review that they did not have access to such an area, plans are in place to ensure a room can be made available to them.

Duty of Candour training

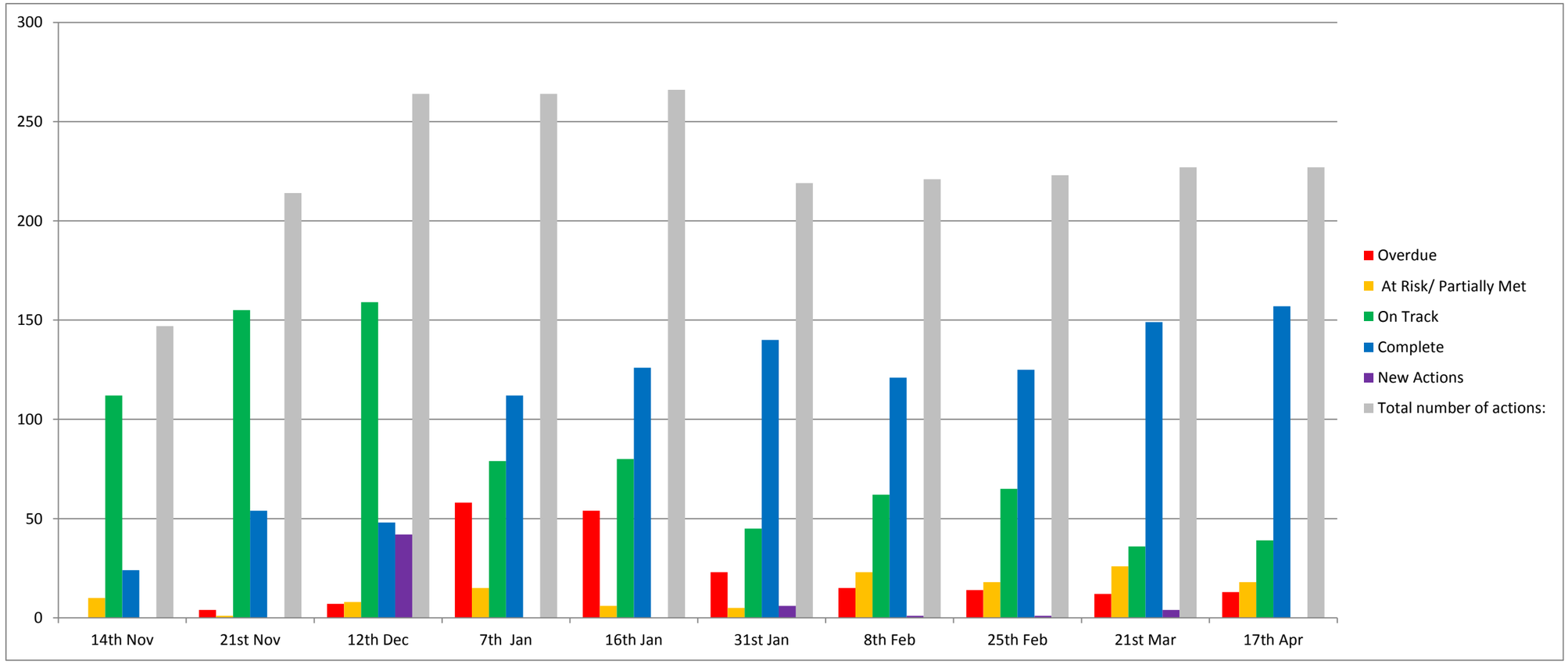
The duty of candour training has been written but is waiting to be uploaded to ‘Greenbrain’ the new training platform, this will happen by the end of June 19.

PROGRESS

	14th Nov	21st Nov	12th Dec	7th Jan	16th Jan	31st Jan	8th Feb	25th Feb	21st Mar	17th Apr
Overdue	0	4	7	58	54	23	15	14	12	12
At Risk/ Partially Met	10	1	8	15	6	5	23	18	26	18
On Track	112	155	159	79	80	45	62	65	36	38
Complete	24	54	48	112	126	140	121	125	149	159
New Actions			42	0	0	6	1	1	4	0
Total number of actions:	147	214	264	264	266	219	221	223	227	227

NB: Executive Well Led actions and Use of Resources actions are identified for reference but not included in the count from 16th January onwards.

Progress on action being tracked



SAFE			
Requirements - Unscheduled and Emergency Care	**Source**	**Status**	**Outcomes / Process/ Evidence**
1.1. The trust must ensure that there is an effective system in place to assess and monitor the ongoing care and treatment to patients whilst in the emergency department. This includes, but is not exclusive to, the monitoring of pain administration of medicines, tissue viability assessments, nutrition and hydration, falls and early warning scores with regular ongoing monitoring.	U&EC MUST DO S31 29A, R12 2015 report(S)		**Outcomes:** • **95 % Compliance rate in ED Checklist** • **PAUs are open on both sites** • **95% compliance rate in NEWS /PEWS** • **95% compliance in pain assessments where appropriate** • **80% of staff PILS/Paed Aims trained** • **90% of stable workforce to be APLS trained** **Process:** • **Management of Children SOP** • **ED Full Protocol** • **ED Improvement Plan**
1.2 The trust must ensure the environment in the emergency department accommodates the needs of children, young people and accompanying families in line with the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2012).	U&EC MUST DO S31 29A, R12		
1.3. The trust must ensure an appropriate early warning scoring system is consistently used during the initial assessment process and during the ongoing monitoring of children and adults attending the emergency department for care and treatment	U&EC MUST DO S31. 29A, R12		**EVIDENCE** 1. **Weekly reports as part of S31 Action Plan** 2. **Audits of ED Safety Check list use** 3. **DPR and Divisional Governance Meeting including M&M meetings (2 weekly)** 4. **Safe Staffing reports** 5. **Vacancy rates in ED (CQC Dashboard)** 6. **Audit R results** 7. **Peer Review reports – to include spot check on conditions**
1.4 The trust must ensure pain assessments are routinely carried out in the emergency department in line with the Royal College of Emergency Medicine guidelines for both adults and children	U&EC S31		
New Must dos from CQC inspection on 4/2/19			
1.5 Ensure patients receive a timely assessment of their care needs and that a plan of care is established and delivered in line with national best practice.	U&EC Inspection report		
1.6 Ensure patients receive care and treatment in an environment which is fit for purpose and meets national standards.	U&EC Inspection report		
1.7 Ensure staff consistently utilise safety measures as determined by trust policy.	Inspection report		
1.8 Ensure the emergency department operates an effective and safe process for receiving and assessing patients who self-present to the department.	U&EC Inspection report		

Ref	Action	Who	Due	Update	Status
Cond 1	Establish criteria for eligible staff to have triage training: 12 months experience and competent in all aspects of acute care	HoUC	09/08/18	**08/11/18** Criteria established and applied	Complete

	Manchester triage tool training completed.	HoUC	30/08/18		**08/11/18** There are sufficient numbers of staff trained to ensure rotas are covered on both sites. However, we plan to increase the number of staff trained at BNHH to achieve the 90% target. The next available training date to achieve this is on 4 November.	Complete
	Streaming training day for those not yet completed 9/56 staff	HoUC	08/12/18		**08/11/18** The next training day is 8th December	Complete
	New SOP implemented for triage of children	HoUC	09/08/18		**08/11/18** SOP implemented	Complete
	Audit of paediatric screening compliance (against SOP above)	HoUC	31/12/18		**08/11/18** Weekly audits are ongoing - this includes routine pain assessments for children 09/01/19 the new audit of the ED checklist includes pain assessments	Complete
	Streaming flowchart and triage process on display	HoUC	09/08/18		**08/11/18** Flowchart and process on display	Complete
	Implement Bristol Shine Tool:	HoUC	02/11/18		**08/11/18** HHFT ED safety checklist is a locally adapted version, which is in use. This has been mapped against the Bristol Shine Tool, and is being used in the department.	Complete
	Monitor paediatric patient harms and sharing lessons learned (DATIX) within ED M&M meetings.	HoUC	09/08/18		**08/11/18** All incidents are currently under review by the ED governance lead and Divisional governance team to ensure actions are taken and any identified learning can be shared. 31/12/18 Incidents are now shared at M&M meetings	Complete
	CCG assurance visits (first visit 8 Aug)	HoUC	09/08/18		**08/11/18** Visit completed, but CCG to be involved in peer review process	Complete
	Responses to NHS Choices and patient feedback to be acted upon	HoUC	09/08/18		**09/01/19** Patient feedback is displayed in the EDs and discussed at Comms Cell/ Stand up for Standards as well as discussed in Governance Meetings	Complete
	NEWS training ongoing, with planned Trust-wide implantation of NEWS2 by the 1st October 2018	HoUC	01/10/18		**08/11/18** NEWS 2 implemented	Complete
Cond 2	Rota planned 6 weeks in advance	HoUC	31/12/18		**08/11/18** Following a change of process, all shifts have identified paediatric competent, nursing staff on duty. A spot check audit on 8th November confirmed paediatric trained staff were on duty. The Department has reviewed the forecasted rota for the coming six weeks and an identified, paediatric competent member of the nursing staff is on duty at all times **08/11/18** This condition has been met consistently over the last 16 weeks and there is evidence on the rota for the next 12 weeks that this condition is being met on every shift. This will continue to be reported until it has been signed off by the Trust board as a completed action **03.01.19** this was validated on Peer Review visits **21/3/19** this has been met and identified in the most recent CQC report	Complete
	Procedure for filling unfiled shifts with paediatric trained staff	HoUC	31/12/18		**08/11/18** This condition has been met consistently over the last 16 weeks and there is evidence on the rota for the next 12 weeks that this condition is being met on every shift. This will continue to be reported until it has been signed off by the Trust board as a completed action **03.01.19** this was validated on Peer Review visits **21/3/19** this has been met and identified in the most recent CQC report	Complete
	Named ENP to be identified each shift responsible for monitoring and addressing concerns (green dot)	HoUC	31/12/18		**08/11/18** This condition has been met consistently over the last 16 weeks and there is evidence on the rota for the next 12 weeks that this condition is being met on every shift. This will continue to be reported until it has been signed off by the Trust board as a completed action **03.01.19** this was validated on Peer Review visits **21/3/19** this has been met and identified in the most recent CQC report	Complete
Cond 3	Provide a suitable paediatric awaiting area and ensure that all parents are offered the option to wait there	HoUC	18/01/19 31/03/19 30/4/19	BNHH	**08/11/18** An interim arrangement was immediately put in place. A permanent solution will be in place by mid Jan 2019 **09/01/19** The PAU is due to open mid Feb **21/3/19** Official opening of PAU occurred 15/3/19	Complete

				RHCH	**16/11/18** Spot checked indicated not all parents had been offered the option to wait in the appropriate area. DDN will complete a further spot check **21/11/18** DDN and HoUC have confirmed that staff understand and aware of the requirement to advise parents that there is a waiting area for them. It has been acknowledged that at the moment parent may not choose to utilise the current waiting area but once the new PAU is complete, all parents will be sent there **09/01/19** The PAU is due to open end of April	On Track
	Named ENP to be identified each shift responsible for monitoring and addressing concerns (green dot)	HoUC	09/08/18	**08/11/18** Green dot in place		Complete
	Nurse training matrix and gap analysis undertaken	HoUC	09/08/18	**08/11/18** Gap analysis completed		Complete
	80% of Nursing staff to complete PILS or Paeds Aims training	HoUC	31/12/18	**08/11/18** 88% of staff trained at BNHH, 76% trained in RHCH (82% over both sites)		Complete
	Protocol for access to play therapists in place	HoUC	09/08/18	**08/11/18** Protocol in place		Complete
	Hourly rounding introduced for paediatrics	HoUC	09/08/18	**08/11/18** Hourly rounding in place and part of weekly audit		Complete
	Post event debriefs for all paediatric arrests	HoUC	09/08/18	**08/11/18** No arrests have occurred **03.01.19** this was validated on Peer Review visits, all arrests will be discussed at M&M meetings		Complete
	Trust trauma committee to review all Paediatric trauma cases attending ED (BNHH)	HoUC	09/08/18	**08/11/18** These actions will be on going until embedded in new governance arrangements **03.01.19** this was validated on Peer Review visits, all trauma calls will be discussed at M&M meetings		Complete
	ED Paediatric M&M quarterly.	HoUC	18/09/18	**08/11/18** These actions will be on going until embedded in new are now in place		Complete
	Shared learning for deteriorating paediatric patients	HoUC	09/08/18	**08/11/18** These actions will be on going until embedded in new governance arrangements **03.01.19** this was validated on Peer Review visits, deteriorating paediatric patients will be discussed at M&M meetings		Complete
Cond 4	Medical rota has been managed to ensure that there is at least 1 APLS trained member of staff on each shift.	HoUC	31/12/18	**08/11/18** 81% of medical staff is currently APLS trained. This is sufficient to ensure there is always an APLS training member of staff on duty. 16% of medical staff have been booked on their APLS training. The 3% is currently non-clinical. However we are aiming to increase this to over 90% of the medical staff by the end of December 2017. 06/01/19 this has been achieved and validated during the peer reviews		Complete
	SOP to manage events if no APLS trained individual on shift in place.	HoUC	09/08/18	**08/11/18** SOP in place		Complete
	90% of stable medical workforce to have APLS training	HoUC	31/12/18	**08/11/18** SOP in place		Complete
Cond 5	Review of rotas to ensure nursing provision on each shift (day before review)	HoUC	09/08/18	**08/11/18** Review is in place		Complete
	Ongoing recruitment to support workforce requirements	HoUC	09/08/18	**08/11/18** Recruitment activity is on going and is part of the weekly report		Complete
	Development of the ED Full protocol;	HoUC	12/11/18	**08/11/18** The task and finish group led by an ED Consultant continue to meet. Medical Director has taken on responsibility for completing this protocol and Trust response to ED escalation. This development work continues with engagement from other divisions within the hospital and outside providers to ensure a system approach to supporting ED pressures. The physicians and Directors of the Day are currently in progress of testing the methodology of the protocol for launch Trust wide on 12 November **21/11/18** ED Full Protocol launched, A subsequent action will be identified to monitor the efficacy of the protocol and its impact on patient flow		Complete
	Board rounds to monitor staffing allocation three times a day	HoUC	09/08/18	**08/11/18** Board rounds are in place		Complete
	Staffing escalation protocol; Director of the Day	HoUC	12/11/18	**08/11/18** Escalation process is in place		Complete
	A review of the nursing staffing levels to be undertaken using the ECIST model	DDN/HoUC	31.12.18	**07/01/19** Information from RBH and ECIS has been used to model the staffing requirements		Complete

1.3	A target for PEWs compliance will be set, and an action plan put in pace to monitor compliance	HoUC	24/10/18	**17/10/18:** Sepsis and PEWs assessments are part of the triage of children and paediatric screening process that is part of the compliance audit every week	Complete
1.4	Review pain assessment within HHFT ED safety checklist to ensure compliance with Royal College of Emergency Medicine guidelines	HoUC	24/10/18	**17/10/18:** The pain assessment in use is in line with RCEM guidelines which has been confirmed by the DMD M	Complete
1.4	Produce an overarching operational policy for the management for Children in ED (BHHT/WHCH)	HoUC	31/10/18	**17/10/18:** The operational policy has been developed to take into account the temporary arrangements that are in place until the redevelopments of the EDs are completed. The paediatric admission booklet provides advice and guidance to staff on the management of children. 07/11/18 The operational policy will be amended to reflect the re-development which is due for completion mid Jan 19	Complete
1.1/.4	An ED improvement plan is developed to reflect on the findings in the reports and address all the issues	OD M	29/11/18	**17/10/18:** A draft Improvement Plan has been developed and will be signed off by the Executive Team, OD M and DMD M. This is being presented to the Executive Team on the 25/10/18 **06/11/18** : Plan is due to be presented to the Executive Team on 29th Nov - complete	Complete
All	All the actions will be reviewed and assured via the Peer Review Process – Review to include CCG / RBH/QGM/DDN	CNO	14/12/18	**07/11/18:** DDN to consider most appropriate time for visit and confirm with CNO **21/11/18** Peer review planed for 30th November in BNHH **03/01/19** Peer Reviews have taken place across both sites	Complete
Additional must-dos from 4/2/19 visit	Timely assessment of care needs: To comply with National ED standard assessment times - 15mins - initial observations and 60 mins – seen by Senior Decision Maker	HoUC	30/4/19	**21/3/19 :** Work with NHSI to produce a clear process for managing patients within the Rapid, Assessment and Treatment bays Target to achieve all patients out of RAT bays within 30 mins with complete assessments Work with ED Consultants to ensure patients have seen a Senior Decision Maker within 1 hour 2 hours there is a plan for onward care/referral/home Currently out to advert for ED MH practice Educator to support with timely assessment of patients with mental illness	On track
	Privacy screening in the reception: New doors with amended windows required for MH assessment room	HoUC	31/5/19	**21/3/19:** Privacy screening in reception - working with builders for commencement week starting 25/3/19 Doors have been ordered but 6-8 week waiting time	On track
	Consistently utilise safety measures: NEWS compliance ED safety checklist compliance	HoUC	30/4/19	**21/3/19:** NEWS compliance currently 90% complete for Basingstoke and 100% for Winchester - Trust are currently testing obs machines that will automatically calculate NEWS scores ED checklist – awaiting new printed form which will increase the compliance - currently 90% Basingstoke 100% Winchester. Some concerns re 15 mins obs – HoUC leading a specific improvement drive on this	On track
	Effective and safe process for receiving and assessing patients who self-present: Work with 2020 and NHSI to create a SOP for the streaming process Testing having an extra triage Nurse for more detailed clinical obs (so Nurse does not leave streaming area)	HoUC	30/6/19	**21/3/19:** Targeted recruitment for ED area for local Nurses Basingstoke - Week 2 of sprint phase - 5 more weeks of sprint and 8 week sustain Winchester - 2020 to start mid-April	On track

Evidence Notes:

- At the point that the s31 is lifted outcomes and evidence will need to be reviewed
- Outcomes and evidence to be amended in light of ED Improve plan and to reflect actions from there.

Requirement – Medicine Management	**Source**	**Status**	**Outcomes/Process/Evidence**
2.1 The proper and safe management of medicines at all times.	MED /SURG MUST DO S29A		**Outcomes:** • **Medicine management incidents (CQC**

	R12 2015 report		**Dashboard)** • **90% compliance with fridge monitoring audits** • 100% of safe storage of medicines audits **completed** • **reduction in incidents relating to poor pharmacy support that have caused harm** • Trends in Datix resulting from CD audits to be reviewed by MERG and Divisional Governance Boards **Process:** • **Revised Medicines Policy** • **Process/guidance for the storage, checking and disposing of medicines**
2.2 There are effective medicines management arrangements in place to store administer and dispose of medicines.	MED /SURG MUST DO S29A R12 2015 report		
2.3 The trust must ensure medicines are stored in line with national requirements	MED /SURG MUST DO S29A R12 2015 report		**EVIDENCE** 1. **DPR and Divisional Governance Meeting minutes** 2. **Number of medication incidents** 3. **Compliance with fridge monitoring standards** 4. **Annual safe storage of medicines audit report** 5. **Any failure in CD Audits to be reported to Division and Medicines Event Review Group (MERG)** 6. **Medicines Event Review Group minutes and action Tracker** 7. **Divisional Governance and DPR minutes**
2.4. Staff have sufficient access to pharmacy support	MED /SURG MUST DO S29A R12 2015 report		

Ref	Action	Who	Due	Update		Status
2.1 -3	The Medicines Policy will be reviewed to ensure it contains adequate guidance for staff, on the safe storage of medicines, roles and responsibilities for management of and if required develop implementation plan for revised Policy	CP	30/11/18	**26/10/18** The medicines policy will be presented to the Drugs and Therapeutics Committee meeting on 21/11/18 – any changes to policy will be agreed at this meeting 31/1/19 The policy is done and a summary poster has been distributed to staff		Complete
2.1	An update for all staff will be provided by the Pharmacy Team confirming arrangement for storage, checking and disposing of medicines	CP	7/12/18	**26/10/18** The advisory poster will be signed off by Drugs and therapeutics Committee meeting **12/12/18** Poster was circulated in trust communications		Complete
2.1 -3	6 mthly programme of CD medicines audits will be developed and communicated to Divisions, it will also include requirements for remedial action plans where the audit fails	CP	26/10/18	**26/10/18** Programme is in place already, failures to be reported at MERG.		Complete
2.1/2	Findings from the audits will be built into the Peer Review / Ward accreditation process	CP/ CNO	31/3/19	31.01.19 Peer reviews will be using data and information from medicines audits 21.3.19 Peer reviews have all included audit findings and it is built into the proforma Medicines audit to be amended to include room temperature of treatment room		Complete
2.1	Any findings or learning from incidents discussed at the Medicines Events Review Group will be disseminated to wards /services together with the requirement improvement plans where necessary. These findings will be evidenced at ward /service level	CP	9/11/18	This is now in place and feedback from MERG (of Moderate or above) has commenced since October, findings are always added to the Pharmacy Intranet pages. Divisions receive a quarterly feedback report on medicine incidents. Any CD incidents are fed back immediately		Complete
2.1/2	Medicine incidents will be fed back to Divisions and discussed at Divisional Governance Meetings	CP	31/12/18	Med	**07/01/19** This is now in place for the Division from January onwards	Complete
				Surg	**07/01/19** This is now in place for the Division from January onwards	Complete
				Family	**07/01/19** This is now in place for the Division	Complete
2.1	Medicine management to be a regular agenda item at all Divisional Governance meetings	Divisions	2/11/18	Med	**17/10/18:** Medicine Management has been added to all revised DPR and Divisional Governance Meeting agendas.	Complete
				Surg	**17/10/18:** Will be added to the agenda from the November Divisional Governance Meeting (DGM) and DPRs	Complete
				Family	**26/10/18:** there will be a set agenda with this as an item as from the November	Complete

					Divisional Governance Meeting (DGM) and DPRs	
2.2	The annual safe storage of medicines will be completed by the end of December but any failures will be reported to division immediately and a remedial action plan implemented	CP	31/12/18		**07/01/19** The annual safe storage of medicines audit was completed and the audit is to be shared at the divisional governance meetings	Complete
2.4	Review of pharmacy provision to be developed into a risk assessed implementation report . The report will include • Details of where the current gaps are • Priority of where support is needed • Immediate safety issues • Immediate actions to be taken • Identification of quick wins	CP	16/11/18		**16/11/18** report sent to Chief Nurse, for further discussion 5/12/18 where any additional actions will be confirmed 15/1/19 Report has been received but as yet not approved – this will be considered as part of the business planning cycle	Complete

Evidence Notes

Requirement – Risk Assessment	Source	Status	Outcome / Process/Evidence
3.1 Staff assess the risks to the health and safety of service users of receiving care and treatment and do all that is reasonably possible to mitigate such risks.	MED / SURG MUST DO R12		**Outcome** • **95% compliance VTE assessment (CQC Dashboard)** • **reduction in incidents relating to ligatures** • **50 % reduction in number of red environmental audits** • **5% overdue actions on risk register** • **100% of ward/service areas have an improvement plan that includes the identification of gaps in assessments and an action plan to address.** **Process** • **TSI on ligatures** • **Revised Rik Management Policy** • **Introduction of 6 monthly re-audit of non-compliance with infection control environmental audits** •
3.2 Systems are in place to assess, monitor and mitigate risks relating to the health safety and welfare of service users.	MED / SURG MUST DO		**EVIDENCE** 1. **Ward /Unit Improvement plans** 2. **BI reports on VTE assessments** 3. **DPR and Divisional Governance Meeting minutes** 4. **ED / Ward / Department Risk Register** 5. **Annual Environmental Audits and 6monthly re-audits of non-compliance** 6. **CQC Dashboard**
3.3 The trust must ensure the level of risk in the emergency department is identified, recorded and managed appropriately.	U&EC MUST DO R12		

Ref	Action	Who	Due		Update	Status
3.1	Each ward / service will complete a physical risk assessment of their areas based on the cohort of patient that are cared for , this may include: • Environmental assessment– IPC/H&S/ ligature • Equipment (linked to 4.1)	**Divisions**	~~31/03/19~~ 10/5/19	Med	**07/01/19** awaiting SOP for equipment to understand the requirements for equipment assessments **14/3/19** – ligature risk assessment sent to wards again – DCNs to collate compliance **25/3/19** – ward estate review sent out and to be collated **17/4/19** – ward estate reviews have been collated and returned – currently being reviewed by Associate Director of Estates. A specific discussion is planned at the CQC weekly meeting on 29th April.	On Track

				Surg	**07/01/19** This is in progress but awaiting SOP for equipment to understand the requirements for equipment assessments **14/3/19** – ligature risk assessment sent to wards again – DCNs to collate compliance **25/3/19** – ward estate review sent out and to be collated **17/4/19** – ward estate reviews have been collated and returned – currently being reviewed by Associate Director of Estates. A specific discussion is planned at the CQC weekly meeting on 29th April.	On Track
				Family	**02/01/19** The division has completed all the assessments apart from the equipment assessment. The date for the completion of the equipment assessment is to be confirmed **14/3/19** – ligature risk assessment sent to wards again – DCNs to collate compliance **25/3/19** – ward estate review sent out and to be collated **17/4/19** – ward estate reviews have been collated and returned – currently being reviewed by Associate Director of Estates. A specific discussion is planned at the CQC weekly meeting on 29th April.	On Track
3.1	Each ward / service will complete a patient centred risk assessment of their areas based on the cohort of patient that are cared for , this may include: • Pressure Ulcer • Falls risk • MUST • Pain	Divisions	~~31/01/19~~ 31/03/19	Med	**07/01/19** This is at risk, high risk areas will be completed in Feb, The direct care assessments are in place , but awaiting SOP for equipment to understand the requirements for equipment assessments **20/2/19** patient risk assessment compliance is on audit R **21/3/19** – continued focus on peer reviews – DCNs driving improvement through requesting action plans if non-compliant on audit R	Complete
				Surg	**07/01/19** This is in progress but awaiting SOP for equipment to understand the requirements for equipment assessments **20/2/19** patient risk assessment compliance is on audit R **21/3/19** – continued focus on peer reviews – DCNs driving improvement through	Complete
				Family	**02/01/19** The division has completed all the assessments apart from the equipment assessment. The date for the completion of the equipment assessment is to be confirmed **20/2/19** patient risk assessment compliance is on audit R **21/3/19** – continued focus on peer reviews – DCNs driving improvement through requesting action plans if non-compliant on audit R	Complete
3.1	Once assessments have completed, each ward /service area will include any improvements required into their ward improvement plan to ensure that any gaps or findings are addressed	Divisions	~~31/01/19~~ 30/04/19	Med	**07/01/19** The improvement plan cannot be completed until the final equipment assessment has been completed **21/3/19** To be completed after collated ward estate review findings **17/4/19 -** A specific discussion is planned at the CQC weekly meeting on 29th April.	On Track
				Surg	**07/01/19** The improvement plan cannot be completed until the final equipment assessment has been completed **21/3/19** To be completed after collated ward estate review findings **17/4/19** - A specific discussion is planned at the CQC weekly meeting on 29th April.	On Track
				Family	**02/01/19** The improvement plan cannot be completed until the final equipment assessment has been completed **21/3/19** To be completed after collated ward estate review findings **17/4/19 -** A specific discussion is planned at the CQC weekly meeting on 29th April.	On Track
3.1	The current arrangements for Environment Audits will be reviewed by the IPC Team, with feedback to wards. The Divisions must ensure that actions from any failed audits will be addressed by a remedial action plan	IPC	~~21/12/18~~ 28/02/19	IPC Team	**06/11/18** The IPC have introduced a more robust system of environmental audits that now includes a 6 mthly review, follow up of action plans and improved provision of advice and guidance. The new cycle of audits will commence on 01.12.18 **03/01/19** The Peer Review process has identified that the current cleaning audits are not providing sufficient assurance. Further actions may need to be identified to ensure the current arrangements are robust enough This will then be addressed by the DCN	Complete

					15/01/19 IPC – Annual audits and 6 monthly re-audit of non-compliance will now • Ensure that the audit programme includes nursing responsibility • Management reports to insure right actions/right escalations are completed • NIC/Matron to sign off audit	
				Med	**17/10/18:** Initial H&S environment risk assessments have begun. 7 completed to date. Programme of remainder in development with H&S lead **07/01/19** This cannot be completed until the audits have been reviewed. This will then be addressed by the DCN **15/01/19** DCNs to ensure all audits/ actions plans are signed off by end Feb **28/2/19** DCNs signed off Environmental audits	Complete
				Surg	**06/11/18** Assessments have commenced and areas are also considered in the Surgical Walkaround. Areas for action will be noted in the Ward Folders and discussed at the governance meetings **15/01/19** DCNs to ensure all audits/ actions plans are signed off by end Feb **28/2/19** DCNs signed off Environmental audits	Complete
				Family	**26/10/18** Assessments are reported at DPR but the service needs to consider a way to consolidate actions and to gain assurance that they are complete. All audits are considered at DPR **15/01/19** DCNs to ensure all audits/ actions plans are signed off by end Feb **28/2/19** DCNs signed off Environmental audits	Complete
3.1	The completed assessment will be reviewed by IPC - any findings and resultant actions are compiled into one ward based action plan that will be monitored at DPR	IPC	~~31/12/18~~ 28/02/19	**24/10/18.** The completed assessment is reviewed by the IPC Team and actions for both the area and Estates are considered.		Complete
3.1	The Trust Safety Instruction – Ligature safety audit and risk assessment will be produced by the H&S Advisor to provide advice and guidance to all areas associated with the care of patients at risk of self harm or suicide	H& S A	30/11/18	**24/10/18.** The draft guidance has been produced and is being reviewed in ED. The final document will be produced for CN sigh off by 30/11/17. At that point it will be issued to the high risk areas for them to complete their risk assessments. It will also be available to all wards and areas for general advice and guidance **14/3/19** – ligature risk assessment sent to wards again – DCNs to collate compliance		Complete
			19/12/18	**5/12/18 –** CNO office recommend some amendments. Document to be finalised for use across the Trust. In the meantime, use draft document tested in ED in high risk areas –Paeds / Child Health/ Gastro and Detoc wards **02/01/19** The document has been finalised and circulated **14/3/19** – ligature risk assessment sent to wards again – DCNs to collate compliance		Complete
3.1	The Organisation will implement a wider campaign of "Ligature Awareness" to ensure that vulnerable patients are adequately care for and their specific needs are addressed	CNO/DDN	~~31/03/19~~ 31/5/19	**21/3/19** await appointment of Mental health Nurse		Partially met
3.1	The ED departments/ Charlies DAU/ G2/Northbrook/ Maternity must complete a detailed assessment to identify a place of safety for the care of vulnerable patients (At Risk of suicide or self-harm)	Divisions	~~21/12/18~~ 31/03/19	ED	**18/11/18** The ED place of safety for children is being considered as part of the PAU . redevelopment **03/01/19** The BNHH PAU includes a place of safety for children this is due to be open by end Jan. This is outside control of the Dept. The RHCH PAU is due to open April 19	Complete
				Family	**26/10/18** This is already in place for children, vulnerable children are risk assessed using the local self harm guidelines that includes identification for a place of safety or where care should be given **21/3/19** Maternity have identified a place of safety	Complete
3.1	All divisions will consider and identify a place of safety for the care of vulnerable patients (at risk of suicide or self-harm)- taking into account the Trust Safety Instruction. (TSI)	Divisions	31/12/18	Med	**06/11/18** The Division is considering appropriate places but will await final version of TSI 07/01/19 This has not been progressed and is now outstanding it will be taken forward by the DCN 31/01/19 Division has considered the need for places of safety and subsequent action	Complete

					will be taken forward by the DCN	
				Surg	**06/11/18** The Division is considering appropriate places but will await final version of TSI 07/01/19 This has not been progressed and is now outstanding it will be taken forward by the DCN 31/01/19 Division has considered the need for places of safety and subsequent action will be taken forward by the DCN	Complete
				Family	**26/10/18** this will be discussed at the next divisional meeting . **02/01/19** Places of safety will be formally identified at the next meeting 07/01/19 This has not been progressed and is now outstanding it will be taken forward by the DCN 31/01/19 Division has considered the need for places of safety and subsequent action will be taken forward by the DCN	Complete
3.1	The identified places of safety will be communicated within the Trust and be known to the Matrons and Directors of the Day	Corporate/ Divisions	~~31/12/1~~ 31/03/19		**02/01/19** This cannot be completed until all the Divisions have identified places of safety **21/3/19** DCNs have based this on an individual risk assessment of the patient	Complete
3.1	The VTE / Risk of Bleeding Policy will be fully implemented and compliance will monitored in every Division. The Divisions will achieve 95% compliance	Divisions	~~31/12/18~~ 31/01/19	Med	**17/10/18:** OSM Haemophilia will lead the Divisional compliance response through the Thrombosis Group. **12/11/18** These are part of the regular compliance audits and non compliance actions will be monitored as part of the Ward DPR and raised with individual Consultant Teams **07/01/19** Compliance was over 95% at both sites **21/3/19** compliance was 85.3%	Complete
				Surg	**17/10/18:** VTE and risk of bleeding assessments are completed on every admission and reported via BI. **06/11/18** These are part of the regular compliance audits and non compliance actions will be monitored as part of the Ward DPR and raised with individual Consultant Teams **07/01/19** This has been completed	Complete
				Theatres	**06/11/18** Theatres are identifying a work plan to ensure that EPR can be accessed to ensure that Teams can access the VTE / risk of bleeding assessment that is recorded in individual patient records **07/01/19** This will be confirmed on the Peer Review planned for 10th Jan **31/01/19** The peer review identified that further work is required and is now part of a theatre action plan. This is being overseen by the DCN, and will be completed by end March 28/2/19 on EPR they have created virtual ward documentation for pre-assessment therefore every patient assessed **21/3/19** 98.8% compliance	Complete
				Family	**02/01/19** Maternity – all patients are reviewed throughout pregnancy and on admission. Compliance is monitored at DPR	Complete
3.1-3.3	The Risk Management Policy will be reviewed by the CN and recommendations made to the Directors and Board	CN	~~31/03/19~~ 30/6/19		**18/2/19** The CN has asked NHSI to assist in a full review of the RM framework including the Board level of risk appetite **17/4/19** as above	On Track
.3	The process for identifying the level of risk and appropriate management will be	OD M	26/10/18		**24/10/18** Risks are now discussed at ED site meetings fortnightly, at monthly ED governance	Complete

	included in the ED Improvement plan			meeting and at USC DPR, where the level of risk and management of the risk is identified		
3.1-3.3	The Divisional risk register entries will be reviewed to ensure that all entries are appropriate, have a review date, mitigations and action plans in place for all Business Units	Divisions	31/12/18	Med	**17/10/18:** Divisional Governance lead meeting with all OSMs to review and update risks. **07/01/19** This is now in place for the Division and on the Divisional Governance Meeting agenda	Complete
				Surg	**06/11/18** The divisional risk register will be reviewed to ensure all entries are appropriate **07/01/19** This has been completed	Complete
				Family	**26/10/18** The divisional risk register is discussed every quarter with each business unit. The division will consider how to gain assurance that the discussions are also held at ward / service level	Complete
3.1-3.3	The Risk register will be a regular agenda item on all DPRs and Governance Meetings	Divisions	31/12/18	Med	**17/10/18:** Divisional and Business Unit Risk Registers added to respective agendas	Complete
				Surg	**06/11/18:** The divisional risk register is reviewed every quarter, however the Directorate intend discuss high level risks at every Divisional Governance Board and then implement risk registers for each y ward / business unit , and risks will be discussed at governance meetings	Complete
				Family	**26/10/18** The divisional risk register is discussed every quarter with each business unit. The division will consider how to gain assurance that the discussions are also held at ward / service level	Complete

Evidence Notes:

- **Level of risk in ED is also linked to implementation of ED Full Protocol**

Requirement – Equipment	Source	Status	Outcome/Process/Evidence
4.1. Equipment used for providing care or treatment to a service user is safe for use and is used in a safe way.	MED /SURG MUST DO S29A R12 2015 report		**Outcome:** • **100% of wards /care areas have a environmental audit and any remedial actions are captured in ward improvement plan** • **100% compliance with completed resus audits with no repeat failures** • **100% compliance with completed quarterly IPC Audits** • **100% compliance with completed appropriate cleaning audits** • **100% wards/ care service areas will have competency matrix in place** **Process** • **Equipment maintenance SOP** • **Hoist checking SOP** • **Revised Resus Policy** •
4.2 That premises and equipment are fit for purpose and infection control standards are followed at all time	MED /SURG MUST DO S29A R15		
4.3 There were not always sufficient quantities of equipment to meet the needs of service users	SURG MUST DO S29A R12		**Evidence** • **Equipment testing and maintenance compliance reported to H&S Committee** • **Sink replacement programme reported to H&S Committee** • **DPR and Divisional Governance Meeting minutes** • **Board Reports** • **Ward improvement plans** • **Staff competency matrix** • **CQC Dashboard**
4.4 The trust must ensure resuscitation equipment in the emergency department is safe and ready for use in an emergency	MED MUST DO S29A R12 2015 report		

					• **Peer Review Reports**	
Ref	**Action**	**Who**	**Due**	**Update**		**Status**
4.1/3	The date for a review of those areas identified in the S29A report will be agreed to ensure that changes have been sustained (for locations please see S29A report)	Divisions	~~31/12/18~~ ~~31/01/19~~ 21/01/19	Med	**17/10/18:** Section 29A to be reviewed at DPRs and HoOC to identify resus equipment in place and serviceable. **07/01/19** The actions for medicine at AWMH will be validates on the 10th Jan Peer Review **08/02/19** all areas identified in the S29A action plan have been reviewed and an additional date for a further has been identified **21/3/19** All areas identified in S29A report have been checked on peer reviews and have correct asset tags and testing dates	Complete
				Surg	The areas identified in Surgery will be reviewed during a Peer Review visit. Date yet to be agreed **07/01/19** The actions for surgical wards have been validated but will require further checks, actions for theatres will be validated on the 10th Jan Peer Review **08/02/19** all areas identified in the S29A action plan have been reviewed and an additional date for a further has been identified **21/3/19** All areas identified in S29A report have been checked on peer reviews and have correct asset tags and testing dates	Complete
4.1	The equipment SOP will be reviewed to ensure that it provides a robust framework on the testing and maintenance of equipment	AD E	30/11/18	Equipment SOP has now been produced and is waiting for publication on the Intranet 18/02/19 the SOP requires amendments to include hoists 28/2/19 confirmation received from Karen Banks that the SOP has been amended to include hoists		Complete
4.1	Each ward / service area will develop a 'passport' to ensure that all staff have been trained on the equipment in use. This will include a competency matrix that staff must achieve. The details will be held at ward level and centrally. Competencies will be reviewed at appraisals (aligned to 5.1)	Divisions	~~31/01/19~~ 30/6/19	Med	**07/01/19** This is not yet compete **08/02/19** Peer reviews have identified that in some areas these are in place but as yet not validated across all wards **17/4/19** paperwork has been shared from Southern Health - meeting with Head of Compliance to discuss next steps	Partially Met
				Surg	**07/01/19** This has not been actioned as yet and will be taken forward by the DCN **08/02/19** Peer reviews have identified that in some areas these are in place but as yet not validated across all wards **17/4/19** paperwork has been shared from Southern Health - meeting with Head of Compliance to discuss next steps	Partially Met
				Family	The Division has clear arrangements in place to ensure that staff are trained appropriately. There are robust arrangements for PoC testing but other competencies need to be fully checked. **17/4/19** paperwork has been shared from Southern Health - meeting with Head of Compliance to discuss next steps	Partially Met
4.1	~~Schedule for testing and labelling all equipment will be produced, together with a trajectory for full compliance~~ All hoists will be appropriately labelled to ensure that staff are clear that they are safe to use	AD E	~~31/10/18~~	**06/11/18** All new labelling of hoists is due for completion by 9/11/17. **15/11/18** There has been no assurance of completion for the labelling of all hosts. A schedule for testing has not been received and there will be a need to prioritise high / med / low risk items. The initial action has now been split into to actions . One for labelling and one for testing **21/11/18 :** In terms of this action all hoist have been relabelled with a single one **10.01.19** : during the Peer Review process a number of hoists still have more than one label **31.01.18** The Peer Review visits have confirmed that in the majority of places hoists only have one label. **05/02/19** monthly rounds in place to ensure only one sticker are in place. If any have been added during servicing they get removed at this inspection. **21/3/19** The peer reviews have confirmed that all hoists are appropriately labelled **21/3/19** confirmation from AD Estates all hoists correctly labelled		Complete
4.1	All equipment will be compliant with the safety testing requirements – a trajectory to achieve compliance will be produced identifying high /med/low risk priorities.	AD E	~~31/10/18~~ ~~31/03/19~~ 30/6/19	**15/11/18** A trajectory for compliance has not been produced, actions have been confirmed to identify high /med/low risk items. A trajectory for full compliance of medical equipment PPM is not likely to be above 80% until the end of Jan.		Partially met

					21/11/18 the Medical Devices Group is meeting on 9th December where this action will be discussed and a plan **31/01/19** Compliance is currently at 70%. Additional internal and external support has been secured. Compliance should show and improvement by the end of March **08/02/19** this action is being tracked by the Executive Oversight Committee **21/3/19 –** currently 79% compliance for BNHH and over 70% for RHCH **17/4/19** – currently 79% compliance BNHH, 78% compliance RHCH and 90% compliance for Andover. Aiming for 90% compliance across all 3 sites by end of June.	
4.1	A review of the medical equipment replacement programme to be undertaken to include those items that are under the capital threshold	Divisions	30/11/18	Med	**17/10/18:** All areas requested to review and prioritise all medical equipment required under capital threshold. Divisional review to prioritise and endorse according to risk. Local identification of equipment that requires replacement and flagged as part of capital funding requests.	Complete
				Surg	**17/10/18:** Division has arrangements for the purchasing of equipment under capital threshold	Complete
				Family	26/10/18 Division has arrangements for minor equipment replacement but needs to consider a robust process for larger pieces of equipment that are still under the capital threshold **21/11/18** Division has confirmed that this process has now been identified	Complete
4.2	Any refurbishment within theatres should a review of all theatre sinks against the new Health Building Notes (HBN) standards and a replacement programme with a trajectory for a replacement programme identified and monitored	AD E	~~24/10/18~~ ~~14/01/19~~ ~~14/02/18~~ 31/03/19	**25/10/18:** the sinks that need replacing have been identified. A tender process is in place for replacement over Christmas of 2 sinks at BNHH first and then 1 per month thereafter. There is a potential complete works at RHCH (if contractors available) but the current plan is replace all over the next 12 months. The 2 sinks identified as part of the S29A report are due for replacement 7th and 14th Jan 2018 Issues with manufacture, procurement and installation means that the sinks will now not be installed until mid Feb **31/01/19** Estates have confirmed the replacement programme. Programme to commence 1st Feb and due for completion by end of March **21/3/19** Sinks identified in the section 29A have been completed. AD Estates has asked the Director of Infection Prevention to provide a priority replacement list - all part of capital planning. **17/4/19** Director of Infection Prevention has given the priority areas to Estates – they are HDU, ITU, theatres. This is to be reviewed as part of the capital planning process.		Complete
4.2	The Environmental Cleaning Policy will be adhered to and Audit results and recommendations will be reviewed by the Senior Facilities Management Team monthly in accordance with the policy. The Senior Facilities Management Team is responsible for addressing any issues identified.	Divisions	~~31/12/18~~ 30/4/19	Surg	**17/10/18:** Cleaning schedules are in place to indicate cleaning requirements. Domestic staff carry out weekly cleaning audits in high risk areas such as theatres which are reported to the division and Infection Control Committee. It is rare for a negative result to occur but should this happen immediate action is taken and a repeat audit is carried out within 24 hours. The Division has devised a schedule for a safety walk around and assurance of the changes will be gained on these. **21/11/18** IPC Lead has identified that there are still issues with the cleaning of Theatres, to be raised with AD Facilities The divisions cannot complete any actions until further audit requirements have been agreed **08/02/19** the Cleaning audits and outcomes are being reported to Board, Further work to identify how any failings from the audits are reported to Matrons needs to be explored. **21/3/19** cleaning checked on peer reviews - most have found good cleaning practice **17/4/19 -** Needs consistent monitoring but all peer reviews have found good cleaning practice	Partially Met

				Med	The divisions cannot complete any actions until further audit requirements have been agreed **03/01/19** The peer review s in EDs identified issues with cleaning **08/02/19** the Cleaning audits and outcomes are being reported to Board, Further work to identify how any failings from the audits are reported to Matrons needs to be explored. **21/3/19** Chief Nurse has met with Associate Director for corporations and they have reviewed cleaning - Chief Nurse is assured about cleaning on ED in Winchester. Basingstoke have put in an additional cleaner at twilight. **21/3/19** cleaning checked on peer reviews - most have found good cleaning practice **17/4/19 -** Needs consistent monitoring but all peer reviews have found good cleaning practice	Partially Met
				Family	The divisions cannot complete any actions until further audit requirements have been agreed **08/02/19** the Cleaning audits and outcomes are being reported to Board, Further work to identify how any failings from the audits are reported to Matrons needs to be explored. **21/3/19** cleaning checked on peer reviews - most have found good cleaning practice **17/4/19 -** Needs consistent monitoring but all peer reviews have found good cleaning practice	Partially Met
				Facilities	Issues with audits / standards have been identified during peer reviews, audits and standards to be discussed **08/02/19** the Cleaning audits and outcomes are being reported to Board, Further work to identify how any failings from the audits are reported to Matrons needs to be explored. **21/3/19** cleaning checked on peer reviews - most have found good cleaning practice **17/4/19 -** Needs consistent monitoring but all peer reviews have found good cleaning practice	Partially Met
4.2	Clear guidance will be produced to ensure there is clarity between nursing and domestic responsibilities ensuring equipment /areas are clean and safe to use	CNO / AD F	31/12/18	**03/01/19** this is contained within the cleaning policy and has been circulated to all staff		Complete
4.3	The review of current resuscitation equipment to be assessed by the CN	HoOC /CN	24/10/18	**25/10/18** Review shared with CN		Complete
4.3	The replacement resuscitation equipment to be delivered to the wards with appropriate guidance	HoOC	14/12/18	**24/10/18** HoOC will confirm final delivery date of all trollies and equipment. The first wave of equipment has already been delivered, second wave to be confirmed. Third wave bid to be completed for CFO **08/01/19** The remaining pieces of equipment will be delivered today which means that all areas that were identified as requiring updating or extra equipment due to sharing etc have been rectified.		Complete
4.3	A review of the Resuscitation Policy to be undertaken to ensure that the checking requirements are clear and unambiguous.	HoOC	14/12/18	**24/10/18** The review of the resuscitation policy has been delayed, key members of the team are involved in the delivery of PILS/APLS training in ED **13/11/18** The resuscitation policy has been reviewed and will be shared with stakeholders. This includes new guidance and resus checklists. This will require virtual sign off by PAG. Early messages around the policy will be included in Managers Message and reiterated in December.		Complete
4.3	An implementation plan together with training on the new requirements to be communicated to all appropriate staff.	HoOC	14/01/19	**24/10/18** the implementation plan cannot be delivered until the policy has been revised **16/11/18** Programme to visit all areas with a resus trolley has been put in place to be completed by early Jan. At this point the new checklist will be issued to the matron of the area **03/01/19** programme and checklist communicated to all areas		Complete
4.4	Spot check audits will be undertaken in the ED department and findings reported at DPR	HoOC	31/12/18	This is already in progress. Findings are reported to the Matrons but need to be evidenced at DPRs. Spot check audits of BNHH, RHCH and Andover ate being planned by the Resus Team for early		Complete

				December and January. **03/01/19** Spot check audits were carried out during the Peer Reviews. All checks had been competed	

Evidence Notes:

Requirement – safe staffing	Source	Status	Outcomes/Process/Evidence
1.1 That persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Staff have an appropriate level of life support training to respond to emergencies.	MED/SURG MUST DO R12		**Outcomes** • **95% Appraisal rate** • **80% of appropriate staff are trained in BLS** • **100% of clinical staff will have access to supervision as per the Policy** • **100% of wards will have a competency matrix** • **80% staff will attend Trust Wide induction with 3 mths of starting and** • **100% of "22222" calls in AWMH are audited by the Resus Team** **Process** • **Supervision Policy** **Evidence** • **DPR and Divisional Governance Meeting minutes** • **Divisional dashboard** • **Staff records** • **Resus Audits for AWMH**

Ref	Action	Who	Due	Update		Status
5.1	The Trusts target for appraisals i.e. 95% of staff have had an appraisal within the last 12 mths	Divisions	~~31/12/18~~ 30/4/19	Med	**17/10/18:** Ward level matrix being developed to include all mandatory training and appraisals rates. To include improvement trajectory to meet Trust targets and demonstrate sustainability. **07/01/19** awaiting confirmation of compliance rates but will not be at 95%. Will meet this by March 31/01/19 Improvement in rate continues, on target to meet end March date 21/3/19 Trust wide compliance 71.97% **17/4/19** Trust wide compliance 72% - new appraisal system been introduced which may have meant that % compliance is still not near 95%. Discussion around introducing an 'appraisal season' - currently being reviewed by HR.	Overdue
				Surg	**06/11/18** Compliance rates are slowly improving but compliance rates will not meet the target by end of Dec Will meet this by March 31/01/19 Improvement in rate continues, on target to meet end March date 21/3/19 Trust wide compliance 71.97% **17/4/19** Trust wide compliance 72%	Overdue
				Family	**26/10/18 Maternity Services;** the removal of midwifery supervision has been a significant challenge and a new system was discussed and agreed with the DoP. The service expects to achieve 80% compliance by the end of Dec and 95% compliance by	Overdue

					end of March. All midwives and nurses will move to Clarity as from 31/3/18 **Children's services.** Children's services are facing a similar challenge and expect to be at 95% by end march The Division will improve its current position across all staff groups by 31/12/18 31/01/19 Improvement in rate continues, on target to meet end March date 21/3/19 Trust wide compliance 71.97% **17/4/19** Trust wide compliance 72%	
5.1	The Divisions will develop a robust process to ensure all new starters attend the Trust wide induction and have appropriate local induction according to their role	Divisions	31/12/18	Med	**07/701/19** The division has a robust process in place	Complete
				Surg	**07/701/19** The division has a robust process in place	Complete
				Family	**03/01/19** The division has a robust process in place	Complete
5.1	A training requirement assessment for training inside /outside the Organisation to be completed	Divisions	~~16/11/18~~ ~~31/03/19~~ 31/5/19	Med	**17/10/18:** The ward level matrix being produced to support with the delivery of the trajectory will be used to identify training requirements **19/10/18** Trust wide learning and development needs template to be completed by 16/11/18 **21/11/18** Division is still compiling this 31/01/19 External requirements have been identified by the CNO**.** These will be reviewed by the DCNs and profile confirmed, Internal provision for Stat & Man training has been confirmed	On Track
				Surg	**19/10/18** Trust wide learning and development needs template to be completed by 16/11/18 **21/11/18** Division is still compiling this 31/01/19 External requirements have been identified by the CNO**.** These will be reviewed by the DCNs and profile confirmed, Internal provision for Stat & Man training has been confirmed	On Track
				Family	**19/10/18** Trust wide learning and development needs template to be completed by 16/11/18 **21/11/18** Division is still compiling this 03/01/19 The Division has completed the assessment for training for outside the Organisation. Internal training has been discussed 31/01/19 External requirements have been identified by the CNO**.** These will be reviewed by the DCNs and profile confirmed, Internal provision for Stat & Man training has been confirmed	On Track
5.1	All Divisions will implement the Clinical Supervision Policy	Divisions	31/12/18	Med	**07/701/19** The division has a robust process in place	Complete
				Surg	**07/701/19** The division has a robust process in place	Complete
				Family	**07/701/19** The division has a robust process in place	Complete
5.1	Compliance with life support training (80% of appropriate staff) will be achieved	Divisions	~~31/12/18~~ 31/5/19	Med	**17/10/18:** Ward level matrix being developed to include all mandatory training and appraisals rates. To include improvement trajectory to meet Trust targets and demonstrate sustainability. **07/01/19** Need current compliance 31/01/19 Compliance is currently improving and is at 76% 21/3/19 Compliance is currently improving and is 78% **17/4/19** Compliance is currently at 79%. Condensed training has been introduced for non clinical areas. When Greenbrain is introduced it will make accessing online learning easier. Looking to introduce smartphone online training as well.	Overdue
				Surg	**06/11/18** – division is On Track to deliver **07/01/19** Need current compliance **31/01/19** Compliance is currently improving and is at 77% **21/3/19** Compliance is currently improving and is 78% **17/4/19** Compliance is currently at 79% Condensed training has been introduced for non clinical areas. When Greenbrain is introduced it will make accessing online learning easier. Looking to introduce smartphone online training as well.	Overdue
				Family	**26/10/17.** This is monitored using a local spreadsheet and a trajectory is being used to	Overdue

					ensure compliance **03/01/19** The division has achieved the target **31/01/19** Compliance is currently improving and is at 75% **21/3/19** Compliance is currently improving and is 78% **17/4/19** Compliance is currently at 79% Condensed training has been introduced for non clinical areas. When Greenbrain is introduced it will make accessing online learning easier. Looking to introduce smartphone online training as well.	
5.1	A demand and capacity exercise will be undertaken to ensure there are sufficient training places available	DoP	8/11/18	**18/11/18** An updated forecast for training for next year's has been produced and there is sufficient capacity to ensure training spaces. The HoCO is working with the SMT/Ops Directors to targeted staff who are 'out of date' in a more specific way. The HoCO and the CN are considering the content and frequency of Statutory and Mandatory Training.		Complete
5.1	An assessment of the requirements to support emergency situations at AWMH will be undertaken and agreed	HoOC	8/11/18	**17/10/18:** The assessment for AWMH has been completed by the HoOC but requires sign off by the CN **16/11/18:** assessment received by the Chief Nurse. This action will be closed, any new actions will then be added if required		Complete
Evidence Notes						

Requirement Infection Control	**Source**	**Status**	**Outcomes/Process/Evidence**
6.1 Preventing, detecting and controlling the spread of infections, including those that are health care associated, are managed effectively.	MED /SURG MUST DO 29A R12		**Outcomes:** • **90% compliance with Hand Hygiene audit (CQC Dashboard)** • **<5% of repeat Hand Hygiene audit failures** • **compliance with BBE/PPE audit** **Process** • **Revised standards of dress policy** • **BBE/PPE Audit**
6.2 The risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated are managed effectively.	MED/SUR MUST DO S29A R12		**Evidence :** • **Additional assurance to be gained through scheduled deep dive.** • **DPR and Divisional Governance Meeting minutes** • **Trust Wide Induction programme**

Ref	**Action**	**Who**	**Due**	**Update**	**Status**
6.1	The cleaning schedule for EDs will be reviewed	HoUC	~~19/11/18~~ 31/3/19	**17/10/18:** Cleaning schedule has been reviewed and revised to reflect the increase in patient flow. Disposable cleaning equipment is going to be used in order to prevent and control of infection by allowing cleaning to happen at any time of the day. Domestic services including deep cleaning/HPV is available 24/7/365 **07/01/19** The cleaning schedule was not seen to be adequate a the Peer Reviews – cleaning audits to be revisited **08./02/19** further reviews in ED have been adequate. Service leads have been asked to comment Need to consider impact of PAU and RAT bays,	Complete

				18/2/19 further assurance is required to ensure the deep cleans have happened at both EDs **21/3/19** Chief Nurse has met with Associate Director for corporations and they have reviewed cleaning - Chief Nurse is assured about cleaning on ED in Winchester. Basingstoke have put in an additional cleaner at twilight and this will be reviewed. **17/4/19** There are 3 permanent cleaners from Monday-Friday, a new post is starting from Friday-Sunday. The floor team are there from 6am and every Thursday there is a thorough clean of resus.	
6.2	An announced review of areas identified in the S29A report will be revisited by the IPC	IPC	~~31/12/18~~ 10/01/19	**03/01/19** Peer reviews are planned to be completed by 10th Jan – all actions will have been checked and validated by then **21/3/19** awaiting update from IPC team **17/4/19** update has been given		Complete
6.2	The Standards of Precaution Policy will be reviewed to ensure that there is clear guidance on the Bare Below the Elbows and the use of PPE and ensure implementation	IPC/ CN/CMO	18/11/18	**07/11/17.** The standards of dress policy will be issued to all new starters once it has been through PAG,. This will be going back out to consultation and will be a Jan'19 PAG. The Standard precautions policy has been reviewed and some minor changes are being made but not in relation to BBE and PPE as these were already clearly laid out in the policy. The BBE and PPE message will be included in the Comms Plan.		Complete
6.2	Statutory and Mandatory compliance with Hand Hygiene will be reviewed at DPRs , any resulting Remedial Action Plans put in place and actions reviewed at DPR	Divisions	23/11/18	Med	**17/10/18:** In development with Ward score card and has been added to all revised DPR and Divisional Governance Meeting agendas.	Complete
				Surg	**23/10/18** has been added to all revised DPR and Divisional Governance Meeting agendas.	Complete
				Family	**26/10/18** this will be added to the DPR agenda	Complete
6.2	Additional BBE and PPE audits will be implemented – and will differentiate between medical / other clinical staff	IPC	~~31/01/18~~ 31/03/19	**07/11/18** BBE and PPE audits are in development and will be implemented via Audit R by the end of Jan 05/02/19 New audit tool for BBE and PPE audits will be trialled in Mar 2019 alongside the quarterly hand hygiene audit		On Track
Evidence Notes						

Requirement Safe Staffing	**Source**	**Status**	**Outcomes/Process/Evidence**
7.1 The trust must ensure that there are a sufficient number of suitably qualified, staff deployed throughout the emergency department to support the care and treatment of patients.	U&EC MUST DO S31 R15 2015 report		**Outcome:** • **80% compliance with Statutory and Mandatory training** • **Compliance with S31 conditions** • **Compliance with standards in Safer Staffing Report** **Process** • **Paediatric Competencies in OPDs**
7.2 The trust must ensure that there are sufficient numbers of suitably qualified staff competent to care for children on duty in the emergency department at all times. In accordance with the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012).	U&EC MUST DO S31 R15 2015 report		**Evidence:** 1. **Vacancy rate ED (CQC Dashboard)** 2. **DPR and Divisional Governance Meeting minutes** 3. **Paediatric trained nurses in OPD** 4. **S31 reports** 5. **HR / Workforce Reports to Board** 6. **Safe Staffing reports**
7.3 There are adequately trained and skilled nursing staff at all times to meet the needs of patients (includes: There are sufficient adequately trained and skilled staff on all wards to meet the needs of the patients accommodated. / There are sufficient adequately trained and	MED/SURG MUST DO		

skilled staff on elderly care wards to meet the needs of the patients accommodated.)	R15 2015 report		**7. Peer Review Reports** **8. Management of Children SOP**
7.4 The trust should consider implementing a lead for mental health in the department	U&EC SHOULD DO		
7.5 The trust should consider implementing a lead nurse for children's emergency care at Royal Hampshire County	U&EC SHOULD DO		

Ref	Action	Who	Due	Update	Status
7.1	In areas where children are looked after (ENT/Ophthalmology / Dental) Divisions will ensure that staff have the appropriate qualification/ competency	Family Division	31/03/19	**26/10/18** All OPD areas have dedicated paediatric waiting areas. At the BNHH site children attending Ophthalmic and ENT clinics are accompanied by paediatric nurses. Dermatology clinics are not supported by paediatric trained nurses currently. There is a plan to explore the possibility of a dedicated children's clinics which could then be supported by paediatric nurses. At the RHCH site children attending Ophthalmic and ENT clinics are accompanied by paediatric trained nurses. At the AWMH site there is currently no paediatric trained nurse support at present. The possibility of having an annual paediatric competency assessment for the OPD nursing team at AWMH is being discussed **15/11/18** Paediatric competencies are being developed for all OPD areas	Overdue
7.1	A review of staffing number and skill mix for EDs will be undertaken, using support from 'Buddy Trust' data	ED	14/12/18	**07/01/19** This has been completed	Complete
7.2	ED must ensure that suitably qualified staff are on duty	ED		Please see actions in 1: Condition 5	Complete
7.3	A work force plan will be developed to include: • Workforce Recruitment/ Retention - linking with the OD strategy • An annual review of staffing levels by the CNO / Divisions • An automatic review when additional beds are opened • A review of roster compliance • The approval process for capped and high cost agency use • An operational policy to be followed by the Matron of the Day when opening additional beds at short notice including a risk assessment.	CN	~~30/11/18~~ ~~19/12/18~~ 8/04/19	31/01/19 the workforce review for nursing has been completed, additional plans / workforce models will be included in the business planning cycle which is due for completion on the 8th April 17/4/19 – staffing paper has been to Board and there is a recruitment and retention plan	Complete
7.4/5	The paediatric lead nurse role will be considered as part of the development of the Paediatric Assessment Areas	Family Division	8/11/18	**26/10/18:** There is a Clinical Lead / Matron for Paeds across both sites who provides oversight, guidance and leadership when required	Complete
7.4	The department will consider the role of a lead nurse for MH	ED	21/11/18	**18/11/18** The lead for MH issues has been included on the HOUC job description and is the nominated lead	Complete

Evidence Notes

Requirement - Endoscopy	Source	Status	Outcomes/ Process/ Evidence
8.1 Safety Checklists were not fully completed for endoscopy procedures	MED MUST DO S29A R12		**Outcome** • **0 breaches of MSA in endoscopy** • **100% compliance with WHO checklist** **Process** • **MSA Policy**
8.2 Endoscopy patients were not treated in a single sex environments	MED MUST DO		**Evidence** • **MSA breaches reported at DPR**

				S29A R10	• **DPR and Divisional Governance Meeting minutes**

Ref	Action	Who	Due	Update	Status
8.1	All areas will be 100% compliance with the WHO checklist in accordance with the Policy	Med	31/12/18	Endoscopy to confirm that amended checklist that is being used is JAG accredited and is identified in the Policy **07/01/19** This will be validated during the Peer Review Visit on 10th Jan **15/1/19** WHO checklist is in place and monitored by OSM / Matron	Complete
		Maternity	31/12/18	**26/10/18:** Compliance with the WHO checklist is monitored quarterly and has just been completed for Q2. The division will complete a spot check audit against step 5 within the quarter rather than wait until Jan for the next results. This will be reported to the divisional governance meeting **15/11/18** Maternity to confirm that the amended WHO check list in place is compliant with the policy **03/01/19** this has yet to be completed 18/2/19 The WHO check list audit in maternity currently only covers 3 steps, to be reviewed with DCN on 22/2/19 25/02/19 Check list used by Maternity covers all 5 steps under the RCOG guideline. DCN to review current c Section Policy to ensure that there is a clear link between the WHO Stprs including debrief and the current form	Complete
8.2	Breaches of the single sex lists will be reported at DPR	OD S	2/11/18	**17/10/18:** All breaches are now reported via Business Intelligence and reported to Board , as part of the Board papers there have been no breaches in endoscopy	Complete
8.2	The MSA Policy - complete approval and sign off process	CNO	30/11/18	**15/11/18** Policy due at PAG in November and includes best practise for all areas. **21/11/18** Policy approved	Complete
Evidence Notes JAG accreditation achieved in December 18					

EFFECTIVE			
Requirement - Outcomes	**Source**	**Status**	**Outcomes/Process/Evidence**
9.1. The trust must ensure patient audit outcomes are routinely shared with all staff in the emergency department and appropriate actions taken where results do not meet national standards.	U&EC MUST DO R17		**Outcome** • **Governance meetings in EDs how evidence of sharing outcomes/ learning of audits** • **Regular review of local and national audit outcomes,** **Process** • **Review of Audit R** • **Standardised Agendas for DPR**
9.2 The trust should ensure the emergency department participate in more clinical audit to be able to evidence care is being provided in line with national recommendations and best practice.	U&EC SHOULD DO		**Evidence** • **DPR and Divisional Governance Meeting framework and minutes** • **M&M meeting notes for ED** • **Annual audit programmes in each division** • **PSEEG actions meeting notes** • **ED Improvement plan** • **ED audit programme**

Ref	Actions	Who	Due	Update		Status
9.1	A review of Audit R will be undertaken	CNO	16/11/18	**21/11/18** This has been completed by the CNO and the Matrons will now review the use of Audit R in individual areas, The information for Audit R will be used in the Peer Reviews and on the CQC dashboard. The CN has also changed the way in wich the data is presented to Board		Complete
			19/12/18	5/12/18 – Matrons have reviewed the Audit R questions. CNO to update Audit R tool for implementation.		Complete
			~~31/3/19~~ 31/5/19	18/2/19Further review of Audit R to be undertaken to ensure that the outcomes are correctly calculated 21/3/19 Full review of Audit R currently being undertaken by AD Governance and DCN Children and Families division		On track
9.1	The requirements, outcomes and improvement plans in relation to National and local audit programmes will be discussed and agreed routinely at Divisional Governance meetings and reported to PSEEG on a quarterly basis	Divisions IADG/ AMD's	31/12/18	Med	**07/01/19** The DCN will be taking action to ensure robust processes are in place **17/4/19** DCN and Clinical Director discussed audit at Divisional Governance Board – robust process in place – audits regularly discussed at Divisional Governance Board meetings to share good practice and improvements	Complete
				Surg	**03/01/19** The division has a robust process in place	Complete
				Family	Division have confirmed that these are now part of the DRP agenda	Complete
9.1/2	Divisions will confirm the process of agreeing local audit programmes and the way in which they will be monitored	Divisions	16/11/18	Med	12/11/18 the Division is compiling a Divisional process to identify where audits are taking place, this plan will be monitored at DPR **07/01/19** The DCN will be taking action to ensure robust processes are in place **17/4/19** DCN and Clinical Director discussed audit at Divisional Governance Board – robust process in place – audits regularly discussed at Divisional Governance Board meetings to share good practice and improvements	Complete
				Surg	**06/11/18** Ward folder will include a Quality Project section where outcomes and actions will be managed and monitored and then reported to DPR. All	Complete

					wards will have this in place by 01.01.19 Consultant teams have individual clinician who oversee audits **03/01/19** The division has a robust process in place	
				Family	**26/10/18:** There are Clinical Audit Leads for Women's Health and Children's services who determine the local audit programme	Complete
9.1/2	Audits and outcomes will be shared as a standard agenda item at DPRs and remedial action plans agreed where results do not meet national standards Standard Agenda Item at Governance Meetings in addition to DPR	Divisions	~~16/11/18~~ 19/12/18	Med	**21/11/18** This is now on the DPR Agenda **07/01/19** The DCN will be taking action to ensure robust processes are in place	Complete
				Surg	**06/11/18** Ward folder will include a Quality Project section where outcomes and actions will be managed and monitored and then reported to DPR. All wards will have this in place by 01.01.19 **03/01/19** The division has a robust process in place	Complete
				Family	**26/10/18:** The Clinical Audit Leads report back findings, outcomes and action plan requirements at the Governance meetings, **21/11/18** Division are waiting for Trust Wide guidance to then relaunch how the meetings works **03/01/19** Division have confirmed arrangement for monitoring actions/ remedial action plans	Complete
9.1/2	For ED specifically – in relation to both requirements the actions, above will apply	ED	16/11/18	**17/10/18:** A review of the governance framework has resulted in the development of an annual audit programme, as the beginning of an improvement programme A lead consultant has been identified to ensure that audits are completed, findings shared and appropriate actions taken		Complete

Evidence Notes

Requirement -Incidents	**Source**	**Status**	**Outcomes/Process/ Evidence**
10.1 The trust should ensure there is a positive incident reporting culture where staff get appropriate and timely feedback	MED/SURG SHOULD DO		**Outcome** • **Maintain Middle quartile position in number of incidents reported of NRLS** • **100% of low level/no harm incidents closed by 25 days** • **98% mod (not SIRI) incidents to be closed by 60 days** • **100% of cardiac arrest calls reported as incidents and reviewed** • **100% of SIRIs have included patients and family in setting terms of reference (where possible)** • **Learning in ED is evidenced in M&M meetings** • **Number of incidents in ED is monitored**
10.2 The trust should ensure reported incidents are fully investigated with all opportunities for lessons learnt to be identified and fed-back to staff in an appropriate and timely way (This is also linked to a requirement in the well led domain as a should do)	U&EC R31		
10.3 The trust must ensure staff in the emergency department report all clinical and non-clinical incidents appropriately in line with trust policy.	U&EC MUST DO R1		
10.4 Incident investigations are completed in a timely manner and the patient or family are involved in the setting of terms of reference and are informed of the outcome of the investigation before it is signed off as complete	MED/SURG SHOULD DO		**Evidence** • **Number of unclosed incidents by Division (CQC Dashboard CQC Dashboard)** • **Incidents in ED**
10.5 The trust should ensure that there is an effective process of investigating robustly and for ensuring any learning points are disseminated and communicated to staff in a timely way (This is also linked to a requirement in the well led domain as a should do)	U&EC MUST DO		

	S31 R17		• **DPR and Divisional Governance Meeting minutes** • **No. of open SIRIS >60 working days (CQC Dashboard)** • **Evidence of lessons learnt disseminated** • **Minutes of SERG/PSEG** • **Commissioning Briefs from Sis** • **M&M Meting notes for ED**
10.6. The trust must ensure that learning from incidents is shared with all staff in the emergency department to make sure that action if taken to improve safety	U&EC MUST DO		

Ref	Action	Who	Due	Update		Status
10.1	Trust wide campaign to raise awareness and promote a positive incident reporting culture with a focus on 'Being Open' and the requirements of DoC.	IADG	30/04/19			On Track
10.1	All Low/no harm incidents will be closed with in 25 days	Divisions	~~31/03/19~~ 30/6/19	Med	Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline **21/3/19** CQC dashboard states that there are currently 483 open more than 25 days - in April 2018 it was 852 so significant improvement made **17/4/19** CQC dashboard states that there are currently 497 open more than 25 days - in April 2018 it was 852 so significant improvement made but needs to be reviewed with the Divisional Governance leads as it has not been achieved by 31/3/19 – to be discussed at CQC weekly meeting on 13/5/19	At risk
				Surg	Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline **21/3/19** CQC dashboard states that there are currently 483 open more than 25 days - in April 2018 it was 852 so significant improvement made **17/4/19** CQC dashboard states that there are currently 497 open more than 25 days - in April 2018 it was 852 so significant improvement made but needs to be reviewed with the Divisional Governance leads as it has not been achieved by 31/3/19 – to be discussed at CQC weekly meeting on 13/5/19	At risk
				Family	Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline **21/3/19** CQC dashboard states that there are currently 483 open more than 25 days - in April 2018 it was 852 so significant improvement made **17/4/19** CQC dashboard states that there are currently 497 open more than 25 days - in April 2018 it was 852 so significant improvement made but needs to be reviewed with the Divisional Governance leads as it has not been achieved by 31/3/19 – to be discussed at CQC weekly meeting on 13/5/19	At risk
10.1/ .2	All moderate incidents (non SIRI's) and below) open more than 60 working days will be closed against an agreed trajectory	Divisions	~~31/12/18~~ ~~31/03/19~~ 30/6/19	Med	**17/10/18** Given the number of incidents to be addressed the division has identified that it requires 8 weeks to clear the backlog **07/01/19** The number of open incidents is reducing but not yet all completed Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline **21/3/19** The number of open incidents is reducing but not yet all completed **17/4/19** CQC dashboard states that there are currently 49 open more than 60 days - in April 2018 it was 53 so improvement made. CCGs aware of all extensions and agreed	At risk
				Surg	**06/11/18** On Track to achieve **07/01/19** The number of open incidents is reducing but not yet all completed Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the	At risk

					deadline **21/3/19** The number of open incidents is reducing but not yet all completed **17/4/19** CQC dashboard states that there are currently 49 open more than 60 days - in April 2018 it was 53 so improvement made. CCGs aware of all extensions and agreed	
				Family	**26/10/18:** The Division is working to the original set date and significant numbers will have been closed. **03/01/19** The Division have identified that they will not be able to close all Mod incidents in Maternity as these require a full RCA. They will close all low/no harm incidents Action split on 31/01/19 31/01/19 Division has made significant improvements and expects to meet the deadline **21/3/19** The number of open incidents is reducing but not yet all completed **17/4/19** CQC dashboard states that there are currently 49 open more than 60 days - in April 2018 it was 53 so improvement made. CCGs aware of all extensions and agreed	At risk
10.1/2/4	SIRI's open more than 60 days as at 1 November 2018 will be closed against an agreed trajectory	IRCM / Divisions	~~31/12/18~~ 31/03/19	Med	**07/01/19** The number of open SIRIs is reducing but not yet all completed	At risk
				Surg	**06/11/18** On Track to achieve **07/01/19** The number of open SIRIs is reducing but not yet all completed	At risk
				Family	**03/01/19** The Division have identified that they will be unable to close SIRIS as they are subject to HSIB investigation	At risk
10.1-6	Review the Reporting, Managing and Learning from Incident Policy and ensure clear guidance in line with national guidance / best practice regarding: • Reporting of incidents • Effective processes for investigating • Expected timeframes and process for closing incidents • Management of SIRI's • Involvement of patients and families • Methods for disseminating learning / lessons learnt	IADG/IRCM /CN	~~31/12/18~~ 30/6/19	**15.1.19** An initial workshop has taken place to discuss the process and management of SIRIs. The new Quality Committee meets for the first time in Feb and will influence the way in which the process and reporting is taken forward.		On track
10.1-6	Review of SIRI process and SERG with recommendations for improvement	IADG / IRCM/ AMD/CN	~~31/01/18~~ On Going	18/2/19 as the Quality Committee and Board work development continues this will be reviewed. The first workshop has occurred and changes to the process instigated		On Track
10.1	All resuscitation calls will reported as incidents and will be subject to post resus audit and feedback	HoOC	~~31/12/18~~ ~~31/03/19~~ 31/5/19	**24/11/18** : confirmed as an action, HoOC will monitor incidents and review compliance 31/01/19 HoOC will report back to CQC Action meeting in March **21/3/19** Been communicated in mid week messages and also highlighted in SMT's and also at the Resus Committee Meeting. HoOC is meeting with Tamara Everington to discuss an electronic robust system moving forward, in terms of collecting the cardiac arrest data.		On Track
10.3	The reporting of incidents in ED will be monitored	OD M	17/11/18	**17/10/18:** The number of incidents raised is being monitored at governance meetings and is also included on the Trust Wide CQC dashboard. Incidents are discussed at ED Governance meetings		Complete
10.3	ED will identify an effective process to ensure that incidents are investigated robustly	HoUC	31/11/18	**12/11/18** The ED will implement the trust incident investigation policy		Complete
10.6	The ED department will confirm the current arrangements that ensure learning from incidents is shared with all staff in the emergency department	OD M	9/11/18	**24/10/18** The weekly ED Governance meetings have been established with ToRs and set agenda		Complete

Evidence Notes

Requirement- Mandatory Training for ED	Source	Status	Outcome/Process/Evidence
11.1. The trust must ensure all staff in the emergency department are supported to attend mandatory training in key skills in line with the trust target.	U&EC MUST DO R12		**Outcome** • **95% of staff have completed mandatory training** • **80% of relevant staff trained in APLS.AIMS/PILS** • **90% of stable medical staff training in APLS** **Process:**
11.2. The trust must ensure staff in the emergency department are supported to attend the relevant level of safeguarding training in line with the trust target.	U&EC MUST DO R12 2015 report		**Evidence** • **ED Mandatory and Statutory training compliance** • **DPR and Divisional Governance Meeting** • **S31 Reports**

Ref	Action	Who	Due	Update	Status
11.1./ 2	Staff from ED supported to attend mandatory training including safeguarding training to achieve 80% compliance with mandatory training	ED	31/12/18	**17/10/18:** Ward level matrix being developed to include all mandatory training and appraisals rates. To include improvement trajectory to meet Trust targets and demonstrate sustainability. Monitored DPR / DGM. 18/2/19 80% of staff have been trained	Complete

Evidence Notes

Requirement – Training	Source	Status	Outcome/Process/Evidence
12.1. Systems are in place so staff receive appropriate support, training and appraisal to enable staff to carry out their duties safely.	MED/ SURG MUST DO R18		**Outcome** • **80% of staff have completed Stat and Mand training** • **95% of staff have had their annual appraisal** **Process** • **Stat and Mand training review**
12.2. The trust must ensure staff, looking after children in the emergency department, are appropriately trained in paediatric immediate life support (PILS) and advanced paediatric life support (APLS).(Includes The trust must ensure medical staff, looking after children in the emergency department, are appropriately trained in paediatric immediate life support (PILS) and advanced paediatric life support (APLS).)	ED MUST DO S31		• **Compliance rate (CQC Dashboard)**

Ref	Action	Who	Due	Update		Status
12.1	Achieve 80% compliance with Statutory and mandatory training across divisions	Divisions	31/12/18	Med	**17/10/18** On Track to achieve **07/01/19** Need current compliance – 31/01/19 Compliance for Dec was83%	Complete

					21/3/19 Compliance for Feb was 87%	
				Surg	**06/11/18** On Track to achieve **07/01/19** Need current compliance 31/01/19 Compliance for Dec was82% **21/3/19** Compliance for Feb was 87%	Complete
				Family	**26/10/18** On Track to achieve **03/01/19** this has been achieved 31/01/19 Compliance for Dec was80% **21/3/19** Compliance for Feb was 87%	Complete
12.1	Review of Statutory and Mandatory training to confirm the programme and frequency of component parts	CN / AD TWD	31/12/18	31/01/19 Review has been completed		Complete
12. 2	This requirement has been addressed in a number of actions in 5.1 above as well as in the responses to the S31 action plan	HoUC	Weekly	**24/10/18** This action is reported weekly		Complete
Evidence Notes						

Requirement – Consent	**Source**	**Status**	**Outcome/Process/Evidence**
13.1 Staff obtain consent and adhere to the principles of the Mental Health Act 1983 and the Mental Capacity Act 2005.	MED MUST DO R11		**Outcome** • **95 % of appropriate staff have received MHA Training** • **95 % of appropriate staff have received MCA Training** • **95 % of appropriate staff have received Safeguarding Training** **Process**
			Evidence • **MCA training numbers** • **Compliance with safeguard training** • **Training requirement rep0rt to MH and Capacity Committee**

Ref	**Action**	**Who**	**Due**	**Update**		**Status**
13.1	Training analysis for MHA and MCA to confirm: • Roles / numbers of staff who require MHA training • Roles / numbers of staff who require MCA training and a trajectory for training compliance	Divisions / DOD M / AD DWT/ CMO/ CNO	~~30/11/18~~ ~~31/01/18~~ ~~31/3/19~~ 31/5/19	MCA	**31/01/19** Head of Safeguarding (HoS) has confirmed roles that require MCA training and this will be part of Stat and Man training for next year. Sufficient places and resources are available to meet the needs of Divisions	On Track
				MHA	MHA training to be resourced from SHFT **21/3/19** MHA training to be provided by SHFT MH lead for the Trust running an MH training day in May 19 ED are advertising a new Educator in MH role who is responsible for doing a training needs analysis for mental health in ED, design and develop a training program and deliver the program for both EDs. **17/4/19** as above	On Track
13.1	Training programme to be confirmed – including material/frequency/assessment of competence for MHA and MCA	DOD M / AD DWT /CMO /	~~31/12/18~~ 31/5/19	MCA	**07/01/19** The Divisions need support with this requirement, **31/01/19** Head of Safeguarding (HoS) has confirmed training programme including material/frequency/assessment of competence for MCA	Complete

		CNO		MHA	**07/01/19** The Divisions need support with this requirement 31/01/19 this has yet to be confirmed **21/3/19** ED are advertising a new Educator in MH role who is responsible for doing a training needs analysis for mental health in ED, design and develop a training program and deliver the program for both EDs. **17/4/19** as above	On track
13.1	Required staff to attend training for MCA (in line with agreed trajectory)	Divisions	31/03/19	Med	**07/01/19** The Divisions need support with this requirement I31/01/9 this will become part of sat & man training for 19/20	On Track
				Surg	**07/01/19** The Divisions need support with this requirement I31/01/9 this will become part of sat & man training for 19/20	On Track
				Family	**07/01/19** The Divisions need support with this requirement I31/01/9 this will become part of sat & man training for 19/20	On Track
13.1	Required staff to attend training for MHA (in line with agreed trajectory)	Divisions	31/03/19	Med	**07/01/19** The Divisions need support with this requirement **21/3/19** ED are advertising a new Educator in MH role who is responsible for doing a training needs analysis for mental health in ED, design and develop a training program and deliver the program for both EDs.	On Track
				Surg	**07/01/19** The Divisions need support with this requirement	On Track
				Family	**07/01/19** The Divisions need support with this requirement	On Track
13.1	The Chief Nurse will consider the wider requirement for a Mental Health Campaign and identify actions to achieve this	CN	~~31/12/18~~ ~~31/01/19~~ 31/3/19	08/02/19 The MH campaign is still being considered by the CN and is a weakness in the organisation. **21/3/19** CN is working with SHFT to second a Senior Nurse to support EDs and Paediatrics. This has the potential to become a permanent shared post between HHFT and SHFT. A second Safeguarding Nurse has been appointed which will support the implementation of the MCA. Compliance in MCA training is improving but MH awareness is still a weakness within the Organisation. AW confirmed that the Lead Consultant is planning a day of training and skills awareness in May and will be invited to attend the local care partnership meeting to discuss the need to unblock areas in the system.		On Track
13.1	The MH Committee will provide leadership including : • Approving the training programme for MHA and MCA • Monitoring compliance against agreed trajectory for Safeguarding / MHA / MCA training • Risk management	DOD M /CMO	31/03/19			On Track
Evidence Notes						

CARING – please note that a number of the actions also relate to the environmental actions in Infection Control (6)

Requirement – Dignity and Respect	Source	Status	Outcomes/Process/Evidence
14. 1 the trust must ensure that patients receive person centred care and treatment at all times.	U&EC MUST DO		**Outcome** • **100% of wards/care units will have an individual improvement plan** • **80% compliance with Dementia Training** • **Dementia champions in each ward relevant area** • **0 breaches of MSA** **Process** • **Equality and Diversity Policy**
14.2 The trust must ensure that patients are treated with dignity and respect at all times.	U&EC MUST DO		
14.3 The trust must ensure the environment is suitable to meet the needs of all patients, including those presenting with acute or chronic health conditions.	MED/SURG MUST DO R15		

			• **Mixed Sex Accommodation Policy**
14.4 That patient care and treatment are appropriate, meet their needs and reflect their preferences, (including the needs of patients living with dementia.)	MED/SURG MUST DO S29A R9		**Evidence** • **DPR and Divisional Governance Meeting minutes** • **FFT Responses (CQC dashboard)** • **Peer Review reports** • **Inpatient Survey results** • **Ward Improvement Plan** • **MSA Board Report** • **Non clinical bed moves for LD/MH and dementia patients** • **Findings from** Privacy and Dignity Thematic Review
14.5 Care and treatment is provided taking into account of people's privacy and dignity at all times, including relevant protected characteristics	MED/SURG MUST DO S29A R10		
14.6 Patients said that call bells were not answered in a timely manner on Overton ward	MED MUST DO S29A		• **Overton call bell audit**

Ref	Actions	Who	Due	Update		Status
14.1/5	An Equality and Diversity Policy (to include all characteristics) will be developed and will include: • Standardised Equality Impact Assessments • The development of an inclusivity programme • The requirement for each ward to have an Privacy and Dignity improvement plan	CNO/DoP OD M	~~31/12/18~~ 31/03/19	**17/10/18:** Med Div undertaking service profile / audit for equality delivery. Divisional Governance Team to track progress of completion and remedial action required 31/01/19 A Privacy and Dignity Thematic Review is planned for the 11th March. Findings will be reported to Exec Oversight Committee **21/3/19** Equality and Diversity Policy has been to PAG is not due back to PAG until January 2020		Complete
14.1	Each Matron will develop a local improvement plan to address privacy and dignity issues within their area, taking into account FFT and Inpatient Survey results where appropriate	CNO/CM's	31/12/18	**31/01/19** 70% of Matrons have submitted their ward improvement plans **21/3/19** 95% of Matrons have submitted their ward improvement plans **17/4/19** 100% have submitted their ward improvement plans		Complete
14.1/5	Confirm compassionate care training is within divisional training plans and within Trust training and development priorities for 2019/19.	Divisions /AD TWD	31/02/19	Med	**07/01/19** This will be taken forward by the DCN **21/3/19** On all the peer reviews - the reviewers have feedback that there is compassionate care on all wards and departments. On the specific privacy and dignity peer review - there were many examples given of excellent care **21/3/19** Completed ED simulator training around customer care	Complete
				Surg	**06/11/18** There is no divisional training plan – this will need to be taken forward by new DCN **21/3/19** On all the peer reviews - the reviewers have feedback that there is compassionate care on all wards and departments. On the specific privacy and dignity peer review - there were many examples given of excellent care	Complete
				Family	**26/10/18:** This already happens in Maternity **21/3/19** On all the peer reviews - the reviewers have feedback that there is compassionate care on all wards and departments. On the specific privacy and dignity peer review - there were many examples given of excellent care	Complete
14.1/5	MSA policy - complete approval and sign off process Compliance reported at DPR and Board	CNO	30/11/18	**17/10/18:** Trust has undertaken a further review to assess which areas Trust-wide require measures to ensure compliance with the mixed sex guidance and has taken appropriate actions where identified, with a mechanism in place for reporting future breaches. To date BI have not had to report any MSA breaches .The Trust have been invited to join NHSI regional Mixed sex collaborative to review current guidelines **21/11/18** MSA Policy approved and breaches are reported at Board		Complete
14.1/5	All Divisions will confirm the quiet and private areas accessible to them. This list will then be made available on the Intranet	Divisions	~~14/12/18~~ 31/3/19	Med	**07/01/19** There are private areas within the Division but they are not know to all or on the Intranet **21/3/19** this is being reviewed as part of the ward estate review **17/4/19** reviewing the ward estate returns – 5 out of the 27 returns received	Overdue

					haven't a quiet and private area accessible to them. To be reviewed at CQC meeting on 29th April	
				Surgery	**07/01/19** There are private areas within the Division but they are not know to all or on the Intranet **21/3/19** this is being reviewed as part of the ward estate review **17/4/19** reviewing the ward estate returns – 5 out of the 27 returns received haven't a quiet and private area accessible to them. To be reviewed at CQC meeting on 29th Apri	Overdue
				Family	**03/01/19** All areas have quiet and private areas, - not yet published on intranet **21/3/19** this is being reviewed as part of the ward estate review **17/4/19** reviewing the ward estate returns – 5 out of the 27 returns received haven't a quiet and private area accessible to them. To be reviewed at CQC meeting on 29th April	Overdue
14.6	Monthly call bell audits will be completed on Overton and compliance will be achieved when there have been 4 consecutive weeks at 90%	DCN	31/5/19	Medicine	**17/4/19** Still ongoing monthly audit latest results 80% **26/4/19** Still ongoing monthly audit latest results 84%	Overdue
Evidence Notes						

RESPONSIVE					
Requirement- Accessible Information				**Source**	**Status**	**Outcomes/Process/Evidence**
15.1 The trust should ensure action is taken to fully embed the accessible information (AI) standards				U&EC SHOULD DO		**Outcome** • **The trust has a trajectory to ensure it is compliant with AI standards** • **Process** • **Accessible Information Strategy** **Evidence** • **Key standards implemented in ED**
Ref	**Actions**	**Who**	**Due**	**Update**		**Status**
15.1	Develop an Accessible Communication Strategy	IADG	~~31/12/18~~ ~~31/03/19~~ 30/6/19	**17/4/19** contact made with Solent AI lead – lots of resources available. Initial meeting held with AD Governance and Professional Lead SAL. Set up task and finish group for implementation – first meeting planned for June		On track
15.1	The early implementation of key standards for AI in ED will be included in the ED Improvement plan	DOD M HoUS	~~31/12/18~~ 30/6/19	15.1.19 Hearing loops have been purchased for the department and will be installed once all the building works have been completed **17/4/19** contact made with Solent AI lead – lots of resources available. Initial meeting held with AD Governance and Professional Lead SALT. Set up task and finish group for implementation – first meeting planned for June		On track
15.1	Implement the requirements of the Accessible Communication Strategy	Divisions	30/6/19	**17/4/19** contact made with Solent AI lead – lots of resources available. Initial meeting held with AD Governance and Professional Lead SAL. Set up task and finish group for implementation – first meeting planned for June		On Track
Evidence Notes						

WELL - LED		
Requirement - Governance	**Source**	**Status**	**Outcomes/Process/Evidence**
16.1. There are effective leadership and governance processes for the delivery of safe and effective care.	MED / SURG MUST DO R17 2015 report		**Outcome** • **100% of Trust Policies are in date** • **100% of Divisional Policies are in date** • **95% of risks reviews are in date** • **Ward level dashboard are used to monitor quality of care and compliance** • **Governance meetings in unscheduled care** **Process** • **Per Review Scheme**
16.2. The trust must operate an effective governance process within unscheduled care.	U&EC MUST DO R17		**Evidence** • **Divisional DPR meeting minutes** • **Policy Spreadsheet** • **Peer Review Reports** • **Permanent DCNS in post** • **Ward /service level dashboards** • **PAG minutes**

Ref	Action	Who	Due	Update		Status
16.1/2	Review arrangements for Board and Sub Board level meetings	CN	31/01/19	**31/01/19 This has been completed and new committees meet for the first time in feb**		Complete
16.1/2	Develop Quality Peer review process and accreditation scheme	CN / CNO	14/12/18	**03/01/19** Peer Review scheme in place, visits confirmed until end of March **21/3/19** Many peer reviews have taken place - ward/department specific and a more thematic review around privacy and dignity. Ongoing programme being developed for the rest of the year. **21/3/19** review of Salford and other hospitals clinical accreditation schemes has taken place – working with Matrons to develop HHFT's		Complete
16.1/2	Recruit to senior Divisional Head of Nursing roles for Medical Division and Surgical Division	CN / DODM/ DODS	31/12/18	DDNM in Post. DDNS start Jan 2019		Complete
16.1/2	Introduce standard terms of reference and agenda items for divisional governance and performance meetings down to ward / business unit	DOD's / DGL's	30/11/18	Med	**07/01/19** The Division has confirmed this is in place	Complete
				Surg	**07/01/19** The Division has confirmed this is in place	Complete
				Family	**03/01/19** Division has confirmed that this is now been implemented	Complete
16.1/2	All out of date policies to be reviewed and updated	DGL's / PAG	~~31/3/19~~ 31/5/19	Trust wide	**17/4/19-** all level 1 Trust wide policies are in date	Complete
				Med	**07/01/19** The Division has confirmed this is in progress **17/4/19** Division confirmed this is progressing	On Track
				Surg	**07/01/19** The Division has confirmed this is in progress **17/4/19** Division confirmed this is progressing	On Track
				Family	**03/01/19** Division has confirmed that this is now been implemented	Complete
16.1/2	Review risk management arrangements at Divisional level to ensure risk is discussed and risk registers reflect the dates risks are reviewed and updated and new risks added	DOD's /DGL's	31/3/19	Med	**07/01/19** The Division has confirmed that this has now been implemented	Complete
				Surg	**07/01/19** The Division has confirmed this is in progress	Complete
				Family	**03/01/19** Division has confirmed that this is now been implemented	Complete

Evidence Nots

Requirement - FPPR	Source	Status	Outcome / Process/ Evidence
17.1 The trust must ensure that all FPPR checks are carried out at appointment and reviewed on an annual basis and that evidence of these reviews is documented	Corporate MUST DO R5		**Outcome** • **All Directors will have an in date FPPR check** • **100% compliance for the checking of all Directors** • **Individual files for all Directors** **Process** • **FPPR Process** **Evidence** • **Annual Report to Board**

Ref	Action	Who	Due	Update	Status
17.1	All FPPR checks have been carried out and a new process has been implemented	CS	10/10/18	**17/10/18:** These separate component parts of the system have now been brought together under one system overseen by the Company Secretary. Each director has had a new file set up which is held by and maintained by the Company Secretariat Office. In terms of any new director appointments, the Company Secretariat Office will direct the HR department to carry out all necessary appointment checks on the director and will receive copies of the evidence of each check being completed satisfactorily.	Complete
17.1	The Company Secretary will continue to conduct the periodic on-going searches and collate the annual self-assessments and will store evidence of the completion of these on the single file per director	CS	10/10/18	**17/10/18:** The Company Secretariat Office now holds all files and information previously held by the HR department, has reviewed any gaps in files and is working with the HR department to complete any such gaps.	Complete
17.1	An annual review will be conducted by the Company Secretary to ensure that files are complete, in addition to the annual self-assessments., and will be reported to Board each May	CS	30/06/19		On Track

Evidence Notes

Requirement – Confidential Information	Source	Status	Outcome/Process/Evidence
18.1 Patient confidential information is handled appropriately in clinical areas	**MED/SURG s29A R10**		**Outcome** • **90% compliance with IG audits in relation to WhiteBoards** **Process** • **Data Security and Protection Policy** **Evidence** • **IG Compliance audits** • **Matrons Message** •

Ref	Action	Who	Due	Update	Status
18.1	Interim message with guidance for staff to be issued by CN	CN	~~17/11/18~~ 19/12/18	**18/11/18** The Trust position on Whiteboards going forward is that they will display patient names but via consent so if the patient objects to this, then the Whiteboards will only show initials. **21/11/18** CNO to ensure that guidance is included in the Comms Plan **5/12/18** – CNO to confirm guidance is issued **03/01/19** Guidance has been provided and included in Trust comms **21/3/19** Some patient identifiable data (patient's names only) found on whiteboards without	Complete

				patient consent on peer reviews. Guidance has been resent out by Comms in 2 midweek messages	
18.1	Agree standards for the handling of patient information (PID) in clinical areas and ensure these are reflected in the Trust Information Governance Policy (now Data Security and Protection Policy)	CNO / DPO	31/12/18	Policy is due at PAG in November **21/11/18** Policy approved at PAG. Messages to be included in Comms plan	Complete
18.1	Review content of Data Protection training and ensure standards are included	CNO/DPO	**31/12/18** **28/02/19**	**31/01/19 this could not be completed until the Policy was approved but has been confirmed**	Complete
Evidence Notes					

Requirement – Duty of Candour	**Source**	**Status**	**Outcomes /Process/Evidence**
19.1 There is training and support for staff to support understanding and application of the Duty of Candour (DoC)	**MED/SURG SHOULD DO**		**Outcome** • **100% compliance with 3 stages of DoC for closed incidents** **Process** • **Being Open Policy**
			Evidence • **Being Open Policy** • **Training and education material** • **Stat and Man Compliance matrix** • **TNA for Stat and Man**

Ref	**Action**	**Who**	**Due**	Update	**Status**
19.1	Trust policy review and update to reflect the statutory requirements of 'Duty of Candour' and principles of 'Being Open'	IADG	31/12/18	**15.1.19** Policy has been approved by PAG	Complete
19.1	Develop training and education material and resources in relation to Duty of Candour and principles of 'Being Open'	IADG	~~31/12/18~~ 01/01/19	**15.1.19** Draft training material is in development	Complete
19.1	Training needs analysis of mandatory training to include DoC	IADG / AD TWD	31/12/18	**15.1.19** This is linked to the wider action around stat and Man training. **21/3/19** the e-learning training from Southern health has been adapted to suit HHFT The face to face training pack is being developed and will be complete by 31/3/19 **17/4/19** this has been delayed due to the installation of greenbrain. Should be up and running by 31/5/19	Overdue
19.1	Implementation plan with trajectory for the delivery of training programme for Duty of Candour	IADG / AD TWD	31/12/18	**15.1.19** This is linked to the wider action around stat and Man training. **17/4/19** this has been delayed due to the installation of greenbrain. Should be up and running by 31/5/19	Overdue
Evidence Notes					

Trust Wide Actions		**Source**	**Key Performance Indicators**
There are a number of actions the Trust will be undertaking that have been identified within the reports: These not counted in the overall count			
20.1	Improve the timeliness of complaint responses: The report noted that complaints were not always responded to in a timely manner	Final Inspection Report	**Complaints performance** % responded to within 25 working days / timeframe agreed with complainant will be captured on the CQC dashboard
20.2	Theatre Productivity: The report noted that Theatre utilisation rates were poor, staff thought this was due to various factors including the way theatre	Final Inspection Report	**Quality Priorities reports to Board**

	lists were organised, lack of equipment, last-minute patient cancellations and staff availability.		
20.3	Bed Moves The report noted that in both Medicine and Surgery there was a high number of non-clinical bed moves, including at night, with some patients moving two or more times. This could impact on patient's continuity of care and their well-being, especially where vulnerable patients were moved.	Final Inspection Report	Patients moved more than 3 times will be presented on the CQC Dashboard
20.4	Length of Stay: (LOS) The final inspection report noted that the Length of Stay in Medical non-elective patients, average length of stay was 8.6 days, which is higher than the England average of 6.4 days. In addition in the Surgery Evidence appendix there are a number of comment around LOS in Orthopaedics for Hip fractures being in the bottom 25% of Trusts, The average length of stay for all non-elective patients at Royal Hampshire County Hospital was 7.2 days, which is higher compared to the England average of 4.9 days, and patients undergoing major bowel resection had a post-operative length of stay greater than five days.	Final Inspection Report	
20.5	Seven Day Working The inspection report noted that the Trust did not have a strategy for implementing clinical standards for seven-day working in Medicine and Surgery – in that not all services in the surgical departments were offered seven days a week. Services that did operate mostly had limited capacity.	Final Inspection Report Surgery Evidence Pack	**Seven Day Working Strategy presented at Board**
20.6	Health Promotion The report noted the limited access to Health Promotion information in ED	Final Inspection Report	
20.7	Harassment, bullying or abuse The report noted that whilst the national staff survey reported that the percentage of staff experiencing harassment, bullying or abuse in the last 12 months was the same as other acute trust, we heard from various staff groups and whistle blowers who contacted us during our inspection, raised concerns that there was a culture of bullying and harassment which the trust had recognised but needed to address. It did note that he board were reported to be committed to addressing. It also said that within Medicine; creating a positive culture was not given sufficient priority. There were problems with bullying and harassment across services. Managers did not always take action to address staff behaviours that were not in line with the trust values.	Final Inspection Report	
20.8	QI Methodology The report notes that while the trust had a quality improvement (QI) strategy dated 2018-20, that identified the principles for QI and had recently launched a quality improvement academy. There was no trust wide methodology that all projects used. There were not effective structures, processes and systems of accountability in place to support the delivery of the trust's strategy and quality, sustainable services. We were not assured that patients were sufficiently protected from avoidable harm. However it did also note that There were already a number of QI in progress with others at the consideration stage. While this was a relatively new development it did demonstrate that the trust were committed to focusing on continuous learning and improvement. And There were QI champions to support the QI programme and the trust had introduced a QI training programme. This was a relatively new development and therefore we could not assess its impact.	Final Inspection Report	**QI Strategy**

Ref	Action	Who	Due	Update	Status
20.1	Divisions and customer care to develop and implement a recovery plan with targeted interventions and trajectory for improvement Internal audit (RSM) of learning from complaints and serious incidents	IADG/Divisions	30/04/19	**17/10/18:** Actions should include process of formal learning from complaints 31/01/19 Response rate is also discussed at SMT	On Track
20.2	The Theatre productivity programme to identify actions to be taken to improve productivity	Quality Priority Lead	~~28/3/19~~ 31/3/19	**17/10/18:** Report noted sub – optimal use and capacity at AMWH Rise in cancelled ops for non-clinical reasons. Board will be updated in March 06/11/18 This action is being overseen by the Theatre Steering Group – programme plan to be included 31.01.19 Oversight of this action is by the Theatre Productivity Board **17/4/19** Actions have been identified for 19/20 to improve productivity	Complete
20.3	Actions from the Quality Priority to reduce unnecessary bed moves for non-clinical reasons to be identified	COO	31/1/19	**17/10/18:** Report noted patients who were moved twice and late discharges Board will be updated in March **06/11/18 :** Site flow and management arrangements to be clarified by 24/12/17. Action plan	Complete

				in place by 31/1/19 to include • A review of admission criteria for wards to ensure patients are admitted to the right ward at the right time • Plan to ensure that discharges happen earlier in the day to create right beds in right places • An education programme with appropriate staff to ensure that they all understand criteria/ vulnerable patients • Identification of patients who can be moved to include clinical risk assessment – pilot being undertaken on E1. / identification by physicians out 'outliers' • Operational flag to be discussed with BI – daily report/ flag on EPR where patients have been moved multiple times for non clinical reasons 31/01/18 report presented to Board identifying number of patients with LD/Dementia and MH issues who were moved more than one, however this includes clinically appropriately moves. Further work being done with BI to see if exclusions can be applied. Going forwards the Quality Committee will receive reports on bed moves. **17/4/19** Bed moves have been reviewed quarterly as part of the quality priority. Actions taken have been transfer team, 2020 flow improvement project and increased operational support	
20.4	Actions to reduce the LOS in medicine, T&O (specifically hip fractures) and Surgery (post major bowel resection) to be identified		TBC	**06/11/18 for hip fractures:** A peer review has been commissioned regarding #NOF and it has been recognised that we need more Othrogeriatric input. Adverts are out but there is a national shortage of these skills so unlikely to fill all posts in the near future. We are working on a reconfiguration of orthopaedic services but that is proving unexpectedly challenging so will not be achieved in the near future. However these actions link to the GIRFT and #NOF reports.	On Track
20.5	Actions to implement 7 day working plans to be identified	CN	TBC	**Actions to be agreed** **31.01.19** Seven Day Working Strategy presented to Board on 30.01.19 21/3/19 Paper was presented to the Board - compliant with all standards	Complete
20.6	Actions to improve access to Health Promotion in ED to be identified	HoUC	TBC	**17/10/18:** This should also be linked to the Risky Behaviour CQUIN which has deliverables in Q4 – smoke free hospital / alcohol and Quit 4 Life	On Track
20.7	The impact on the Culture Change Programme on bullying and harassment to be identified	DoP	31/3/19	**17/10/18:** Impact on bullying and harassment, with Comms between Teams (matrons and OSMs) • Creating a positive culture • Staff drive to challenge systems and processes • Learning and changes **21/3/19:** This work has started and been feedback to the Board. The latest staff survey will be added as an additional action to review	On Track
20.8	Specific milestones for the QI Programme to be identified	CNO	TBC	**Actions to be agreed:** **31.01.19** The Trust has secured additional 'Buddy Funding' some of which will be used to provide QI training for all Matrons so that it can be used in the implementation of their Ward Improvement Plans **21/3/19** The Trust have a number of QI practitioners and QI coaches embedded across the Trust and milestones to increase those numbers	On Track

Requirement Well Led Action Pan. Executive Actions – these will not be counted in the overall figures

Outcomes:

- **Board are clearly sighted on and assured about the management of key risks**
- **There is clear accountability and demarcation for the quality agenda between executive portfolios**
- **There is clear floor to Board visibility of quality performance**
- **Capital planning process is appropriately prioritised on the basis of clinical risk**
- **Exception reporting to SMT to allow for early escalation of quality concerns**
- **Improved interface between estates and clinical services**
- **Review of Board Papers in April 2019 demonstrates sustained improvements in terms of well led actions**
- **Board Report in May 19 will articulate improvements identified in Board papers and areas for further review.**

Ref	Action	Who	Due	Update	Evidence	Status
21.1	Senior leaders did not demonstrate understanding of the current challenges to quality and sustainability	CNO	January 2019 reports	1) Monthly report to both Exec Comm and Board on new red risks (either newly identified or newly escalated to red status) Minutes of meetings to be more explicit in recording discussions on current challenges Complete. Minutes are now more explicit. 22.01.19first new Bard meeting in January, Board to review action in April to ensure the action is embedded	Board Minutes	On Track
21.2	Not assured that the executive leadership have sufficient focus on quality and safety	Chairman	~~January 2019~~ April 2019	Set up Quality sub committee of the board TORs drafted. First meeting to be in Jan 2019. 22.01.19first new Bard meeting in January, Board to review action in April to ensure the action is embedded	TOR for Quality Committee	On Track
21.3	Ensure fully compliant with FPPR Regulations	Company Secretary	By end of November	Bring all under control of Company Secretariat, such that HR are given specific tasks to complete. This has been completed	Please see above	On Track
				Complete any evidence gaps in existing director files Update 1 DBS and some 2018/19 appraisals to finalise.		On Track
				Company Secretariat Office to conduct annual review and deliver annual statement of compliance to the Board Going to November board		On Track
21.4	Senior leaders did not take action to address known risks identified by frontline staff	CNO	January 2019 reports	See action under 1) above. The new section in the monthly governance report should actions to be taken and a due date for the action. Reported against once complete. 22.01.19 first new Board meeting in January, Board to review action in April to ensure the action is embedded	Minutes of Governance Reports	On Track
21.5	Continue improve the quality of reporting, including more analysis of data to explain spikes and changes	All Execs	January 2019 reports	1) Better triangulation of reporting, both at Trust level and at specialty/ward level – a dashboard to be produced 2) All reports to Board to have a clear front sheet, summarising the key points of the data in the paper 3) Greater focus on the "so what" of the data. 22.01.19 first new Board meeting in January, Board to review action in April to ensure the action is embedded		On Track
21.6	Clarify which reports are presented at other committees and groups to facilitate sharing of information	Chairman & CEO	January 2019 meetings	Review of Executive meeting structure and implementation of Quality and Workforce Committees Update: Proposal going to November Executive Committee 21.1.19 – Company Secretary to produce Organogram ensuring clarity of reporting structure		On Track
21.7	No BME members of the Board	Chairman	March 2019	NED recruitment expected in 2019 Continue to ensure that all avenues are explored to reach BME population aware of Hampshire demographics. Update: Clinical NED JD drafted. Aiming to advertise by end November. Searching for BME candidate.		Complete

				22.01.19please see update on this action below **17/4/19** 2 new NEDs appointed - Ruth Williams and Simon Holmes - both clinical backgrounds		
21.8	Clinical leadership model is medically led, with insufficient nursing input and does not encourage joint working	CNO	January 2019	Julie Dawes reviewing nursing leadership model – recruiting divisional heads of nursing. Family division already have a senior paed nurse and senior midwife. Update: Interim divisional heads of nursing recruited – on in post, one due to start. Permanent structure under review. 22.01.19please see update in TW action plan UoR		Complete
21.9	Limited evidence of open constructive challenge at board level, with no assurance that all options considered and decisions not dominated by individuals	Lauren Wagner	Immediately	NED recruitment expected in 2019 Continue to ensure that all avenues are explored to reach BME population aware of Hampshire demographics. Update: Clinical NED JD drafted. Aiming to advertise by end November. Searching for BME candidate. 22.01.19please see update on this action below **17/4/19** 2 new NEDs appointed - Ruth Williams and Simon Holmes - both clinical backgrounds		Complete
21.12	No NED with a clinical background, meaning an absence of clinical challenge	Chairman	March 2019	Julie Dawes reviewing nursing leadership model – recruiting divisional heads of nursing. Family division already have a senior paed nurse and senior midwife. Update: Interim divisional heads of nursing recruited – on in post, one due to start. Permanent structure under review. 22.01.19please see update in TW action plan UoR 22.01.19please see update in TW action plan UoR **21/3/19** New NED interviews have taken place and awaiting confirmation of appointments **17/4/19** 2 new NEDs appointed - Ruth Williams and Simon Holmes - both clinical backgrounds		Complete
21.11	No mitigation to manage the risks if STP bids unsuccessful	CFO	April 2019	Plan being produced for application for capital loans 21.01.19 The Trust was successful with 1 Wave 4 Capital Bid for Orthopaedic Expansion and the relocation of Pharmacy in Winchester The planning process and more particularly culminating in April 2019 and more particularly the 5 year strategic plan in the summer will identify an intended capital plan and indicated those where we see funding and those that aren't funded. For those that aren't funded, we will have to decide on the funding route. The most likely is that we develop a business case for submission to NHSI. However, there is a long list of Trusts doing the same, and our major plans do not have strong financial paybacks so don't fit in the business case format very well. The other option is some sort of joint venture or managed service, but for major service developments this come uncomfortably close to PFI, which is no longer an accepted way of doing things after the November 2018 budget. Making the business case to NHSI means a delay of probably 18 months from here to the approval or turning down of the case. We have established a small team to look at the ED case, and I would expect some very valuable assessment of staffing implications to come within the next 2 months. But this work is very much pre-business case. And if the conclusion is an increase in our staff costs, then unlikely to make much of a business case		On Track
21.12	Unclear how strategic framework links to other strategies	CEO	April 2019	The 2019/20 planning process is different to previous years and divisional planning is aligned to strategic framework and overall strategy to be documented by April 2019. Strategic framework being embedded through 2019 planning 22.01.19There is a clear link to other strategies and the Senior Leadership team. Board to review		On Track

				action in April to ensure the action is embedded		
21.13	Report said "Not all Board members demonstrated the Trust's values and their behaviour was not challenged"	CEO / Chairman	April 2019	1) Board development training programme 1) Exec training - B&H training 2) Implement reflective practice discussion at the end of every Board meeting, for people to feed back Update: Initial board development with RSM in October 2018. Sourcing board development partner .Exec training Scheduled for January , reflective practise discussion In place 21.01. Board to review action in April to ensure the action is embedded		On Track
21.14	Catastrophic risk of 25 on the risk register but unclear what additional action had been taken and if the mitigation had been reviewed to evaluate why it was not having the desired result	CNO/CMO	January 2019	Risk Committee are more rigorously reviewing risk ratings and articulation of risks. Better documentation of actions taken. Also see action under 1) above This risk has been down rated on review. CNO is reviewing risk management processes. 22.01.19Please see actions in TW action plan		On Track – Not counted in overall actions
21.15	Consider whether CQSC should be a sub-committee of the Board	CEO/Chairman/Company Secretary	January 2019	Agreed to establish a Quality Committee of the board. TOR drafted. First meeting in January 2018. 22.01.19CQSC to be disbanded and new Quality Committee in place		Complete
The following actions were identified in the RSM Audit and are not counted in the overall figure						
21.16	Role of Governor/NEDs/Executives should be clarified	CEO/Chairman/Company Secretary	February 2019	1) Board development training programme 2) Further discussion with CoG the role of the Governor, with reference to the Code of Governance 3) Consider sub committee chairs reporting to Council of Governors rather than Execs presenting board papers. Update: Board development programme being sourced. COG / Board roles to be scheduled for January COG meeting 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.17	Succession planning to consider diversity matched to skills audit	Chairman	February 2019	Nominations Committee of the Board to meet to discuss succession planning Update NomCo Scheduled. Execs working through succession planning conversations.		On Track
21.18	Board impact could be strengthened via improvements in papers, focus on outcomes, adopting reflective practice (continuous improvement), restructuring the agenda and clarifying role and purpose of the Board	CEO/Chairman/Company Secretary	April 2019	1) RSM workshop held on 25 October attended by Board and Top team 2) See actions under concern 5 above 3) Look at ways to restructure the Board programme/agendas Update: Improved clarity of purpose of each paper that comes to board. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.19	The Trust should consider triumvirate operational management to improve the parity of esteem for non-medical leaders	CNO	January 2019	See action under 8 above		On Track
21.20	Improve the ability to hold to account via greater specificity of actions, membership of forums and clarity of roles and purpose	Company Secretary	April 2019	Implement use of a Board action tracker (see attached example) RSM Workshop on accountability in meetings Update: Action tracker drafted. Workshop held in October 2018. 22.01.19Board to review action in April to ensure the action is embedded		On Track

21.21	Development of a credible strategy, developed inclusively and supported by robust plans is required	CEO /CMO	April 2019	Clinical strategy position statement approved by Board Sept 2018 Working with Basingstoke & Deane Council on local planning Update: NHSE have offered funding to pull together the work done to date. 22.01.19Director of Strategy being recruited		On Track
21.22	The Trust needs to ensure that its developing strategy is aligned to wider system requirements	CEO/CMO	April 2019	Workshops with Governors and stakeholders on strategic development. Update: Workshop with Governors in November 2018 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.23	The Trust needs to provide greater clarity to divisions and staff around its future direction	CEO	April 2019	Via the planning process, see action under 12) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.24	The development of the Trust's OD strategy needs to incorporate the development points identified within RSM's review	DoP	March 2019	Review the strategy in light of the RSM comments Update: Review underway with Change Champions. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.25	The respective roles of Board members and Governors should be clarified	Chairman	February 2019	See action under 16) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.26	Operational reporting lines should be reviewed to support clear lines of accountability	CEO	March 2019	Under review Update: Discussion with Execs in November. No significant changes recommended.		On Track
21.27	Committee structure should be reviewed in response to the Trust's current challenges	Chairman /CWO	January 2019	Establish a Quality and a Workforce Committee Update: TOR both drafted. Committees will meet in January 2019. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.28	The Board, as a whole, should look to play a more active role in system working	Chairman /ACEO	March 2019	STP/LCS standing item at Board meetings NED meeting with Lay members Update: NED / Lay member meeting in November 2018. This needs to become a routine forum. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.29	Meeting agendas should be colour coded to identify key areas and timings should be included on agendas so that adequate focus is given to these key matters	CEO/Chairman/Company Secretary	January 2019	This recommendation has been interpreted to mean greater clarity on the purpose of the papers is required. All papers to include a clear articulation of their purpose. Update: Papers have a clearer articulation now. Need to continue to improve 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.30	Action plans should be realistic and followed up thoroughly along with potential impact of action not occurring	Company Secretary	March 2019	Implement action tracker for board and board sub committees Update: Action tracker drafted 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.31	In light of current challenges and absence of a strategy more horizon scanning of emerging national, sector and local issues is required	CEO	December 2018	Update: Monthly CEO report to Board now includes reporting on external issues Completed		On Track
21.32	Risk management should be a regular feature of operational management and Board discussions and help drive agendas		January 2019	See action under 1) above and to be included in DPRs. 22.01.19Please see actions in TW action plan		On Track

21.33	Need for more evidenced challenge		Immediately	See action under 9) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.34	Enhancements to data presentation including benchmarking, SLR, trend data, integration, forward looking and expansion of HR metrics to support the cultural journey		January 2019	See action under concern 5) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.35	IT resources need to be regularly assessed so that the Trust's ambitious IT agenda remains on course and is implemented successfully	Company Secretary / Chairman	January 2019	Consider increased frequency of IT reporting to Board 22.01.19To be discussed by Board and confirmed		On Track
21.36	Review the processes of how the Trust shares and utilises feedback from patients, staff and the public	ADG	January 2019	Patient experience and engagement strategy being produced Update: Schedule for approval at board in January 2019 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.37	Strengthen the current process of how the Trust interacts with third parties (engagement strategy)	HoC	January 2019	Engagement strategy being produced Scheduled for approval at board in January 2019 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.38	Focus on consistency of approach in performance managing all staff	DoP	January 2019	Leadership and OD strategy implementation Update: Strategy approved. Implementation underway. New appraisal system for March 2019. 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.39	The Board should consider the use of team brief and increased social media to increase visibility of Board working	Chairman	January 2019	Part of engagement strategy under 37) above 22.01.19Board to review action in April to ensure the action is embedded		On Track
21.40	Embed QI methodology as business as usual	CNO	January 2019	QI strategy produced – accelerate implementation process Update: Bid to NHSI to increase resource into QI programme.		On Track
21.41	Review the agenda of meetings to include time for reflective practice	Company Secretary /Chairman	December 2018	Insert agenda item on reflective practice/meeting chairs to include it Update: To be included on agendas from December. 22.01.19Board to review action in April to ensure the action is embedded		On Track

Requirement - Use of Resources (These are not Regulatory /	**Source**	**Status**	**Key Performance Indicators**
The following actions were identified in the UoR report and are not counted in the overall figure			
1 Medical job plans are not linked to activity and they are not scrutinised by the Trust.	UOR		**Actions 1 –.4 will be led by the CFO and CMO** **Actions 18.5 -18.8 will be led by CFO**
2: Medical staff have a low reported DCC (Direct Clinical Care) rates.	UOR		
3: The trust does not fully understand its productivity gap in medical staffing or have a plan to address this.	UOR		
4: The trust does not systematically use Service Line reporting or Patient Level Costing to identify high cost areas in the trust.	UOR		
5: The trust has high pay costs per WAU in medical and nursing costs.	UOR		
6: The trust needs an updated estates strategy based on the output of	UOR		

the clinical strategy to address the material levels of backlog maintenance and maximise the benefit of future investment.			
7: The trust needs to improve monitoring and delivery of the pharmacy transformation strategy to ensure delivery of all identified efficiencies.	UOR		
8: The trust needs to improve procedures for dispensing of drugs on wards, as it currently spends well above most trusts in England on low cost drugs.	UOR		

Ref	Action	Who	Due		Update	Status
1- 4	Appoint Divisional Senior Nurses for Medicine and Surgery Division	CN	December 18		The Senior Nurse for Medicine is in post and interviews have been held for the Surgery post **22.01.19** Divisional Chief Nurses appointed for all three divisions	Complete
1-4	Review nursing grade mix across the hospital to optimise benefit of nurse leadership in wards	CN	April 19		**22.01.19** This will be completed as part of the business planning cycle	On track
1- 4	Act on conclusions of recruitment and retention Task and Finish Group	DOP			21.1.19 Over 100 interviews conducted with leavers from 2018 this data feeding in to Change agents & retention document – Work is going on in CNO office now on some things but you should ask Julie Dawes on this. Change Agents have entered the interview part of the investigation phase and are interviewing NEDs, and exec and other in senior team to further define what cultural change may be needed to support clinical quality	On track
1- 4	Work with NHSI productivity team on improving efficiency of rostering of staff	DoF	04/04/19		**22.01.19** productivity assessment are being built into the plan that is due to Board at the end of march and for submission on the 4th April	On track
1- 4	Support the emerging work of Hampshire Isle of Wight STP on developing a Collaborative Bank	DoP	March 19		**22.01.19** a signed contract for all Trusts across the STP that will introduce a collative bank for all staff is expected by the beginning of March	On track
1- 4	Enhance the Theatres and Outpatients productivity work. Commit to expected timetable for scale of improvement. Ensure that there is not substantial downtime in Theatres over (for example) school holidays.	OD/CD Surgery	04/04/19		**22.01.19** productivity assessment are being built into the plan that is due to Board at the end of march and for submission on the 4th April	On track
1- 4	Implement Medirota as a general workforce system for medical staff under the leadership of Medical Directors and Clinical Directors	Divisional CDs	April 19	Surgery	Medirota/CLW fully implemented in surgery	**Complete**
			April 19	Medicine	**Awaiting update**	**On Track**
			April 19	Family	**Awaiting update**	**On Track**
1- 4	Make clear that Clinical Directors are responsible for individual Job Plans within their area of responsibility, including the agreement of the objectives of SPA time.		April 19	Surgery	Clinical Directors in Surgery are currently reviewing job plans in a rolling programme	**On Track**
			April 19	Medicine	**Awaiting update**	**On Track**

				Family	**Awaiting update**	**On Track**
1- 4	Differentiate activity in Orthopaedics between Winchester and Basingstoke sites consistent with GIRFT report, subject to sufficient capital investment being available			First stage of centralising of activity is planned, with Trauma and NOF activity being cared fro at BNHH and corresponding elective work to be carried out at RHCH		**On Track**
1- 4	In 2019/20 annual planning exercise, fully articulate activity plans with reasonable expectations of the capacity inherent in Job Plans.		March 19	Surgery	Capacity planning not yet complete	**On Track**
				Medicine		**On Track**
				Family		**On Track**
1- 4	In 2019/20 – 2023/24 Strategic Plan, establish expectations over continuous improvement in productivity and identify pathway articulation with Out of Hospital work	DoF	31/07/19	**The 5 year strategic plan for the Trust is expected by the end of July**		**On Track**
5	Estate and Property Strategy produced within annual planning process for 2019/20, which supports the clinical strategy and will underpin work over the strategic plan period 2019/20 – 2023/24.	DoF	April 19	**22.01.19Estates strategy is expected as part of the business planning process**		**On Track**
6/7	Subscribe to Refine and Define service	DoF	December 19	Subscription complete		Complete
6/7	Review Pharmacy strategic improvement plan in line with developments since 2016, major estate opportunity in Winchester and the clinical strategy as part of 2019/20 annual planning	DoF/MD Families	April 19	**22.01.19 strategy is expected as part of the business planning process**		**On Track**
6/7	Review Pharmacy support for wards as part of ward skill mix review, and bring closer links with Procurement to ensure optimum buying policy	CP	16/11/18	**The pharmacy support action forms part of the TW action plan -** Review of pharmacy provision to be developed into a risk assessed implementation report . The report will include • Details of where the current gaps are • Priority of where support is needed • Immediate safety issues • Immediate actions to be taken • Identification of quick wins **22.01.19 review was completed and outcome will form part of the business planning process**		**On Track**
6/7	Fully utilise robotic dispensing and other innovations to reduce drugs and medicine going out of date.	DoF /CP	Dec 20	**22.01.19 Robot in place at BNHH, further developments at RHCHC , project expected to begin this year and will be fully in place by 2020**		**On Track**
8	**SLR and PLICs utilised as tools to compare resource allocations and signpost likely productivity**	**DDoF**				**On Track**

	improvements in 2019/20 annual planning and 2019/20 – 2023/24 strategic planning				
8	**Establish Steering Group with intent to identify clear actions for improvement**	**DDoF**			**On Track**

Abbreviations			
Who	**Title**	**Who**	**Title**
CN	Chief Nurse	**DoP**	Director of People
COO	Chief Operating Officer	**DPO**	Data Protection Officer
AMD	Associate Medical Director	**CFO**	Chief Finance Officer
DOD M	Divisional Operations Director - Medical Services	**CS**	Company Secretary
DMD.M	Divisional Medical Director -Medical Services	**IRCM**	Interim Risk and Compliance Manager
DOD S	Divisional Operations Director - Surgical Services	**AD TWD**	Associate Director of Training, Wellbeing and Development
DMD S	Divisional Medical Director - Surgical Services	**TW**	Trust wide
DOD FCSS	Operations Director -Family &Clinical Support Services		
DMD.FCSS	Divisional Medical Director - Family &Clinical Support Services		
CNO	Chief Nursing Office		
IADG	Interim Associate Director of Governance		
HoUC	Head of Unscheduled Care		
DE	Director of Estates		
AD E	Associate Director of Estates	**Source**	**Description**
CEO	Chief Executive Officer	**S29a**	CQC Section 29a Warning Notice
CMO	Chief Medical Officer	**MUST DO**	CQC ‘must do’ action
CP	Chief Pharmacist	**S31**	CQC Section 31 Warning Notice
DGL	Divisional Governance Lead	**SHOULD DO**	CQC ‘should do action
MED	Medical Division	**2015 Report**	Identified as Must /Should in 2015 comprehensive inspection report
SURG	Surgical Division	**‘R’**	Regulatory Breach
U&EC	Urgent and Emergency Care		
CG	CaldIcott Guardian		
HoOC	Head of Operations & Compliance		

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Hampshire Health and Adult Social Care Select Committee
May 2019

Portsmouth Hospitals NHS Trust update

Portsmouth Hospitals NHS Trust (PHT) is providing updates to the Health and Adult Social Care Select Committee on the following issues of interest:

1. **Care Quality Commission (CQC) report following its Focused inspection of the Emergency Department**

    - The CQC published its report on the focused inspection of the Emergency Department carried out at the Trust in February 2019. This paper provides a briefing on findings from the inspection and the Trusts response to date, to help ensure the Trust fully complies with its regulatory obligations.

Care Quality Commission Focused report

The CQC published its focused report on the Emergency Department at Queen Alexandra hospital site, on 16th April 2019. The inspection took place on 25 February 2019.

The hospital has been under considerable pressure over the past weeks and this was particularly so at the time CQC inspectors visited in February. Since the beginning of the year increasing numbers of patients have been accessing the Trust urgent care services, with an additional 1,300 patients attending the ED in February compared to the same period last year.

The CQC recognised that improvements have been made and welcomed the steps the Trust has already taken to help reduce pressure on ED. The report also highlighted that staff feel supported and want to make a difference. Examples of the improvements the inspection noted include:

- New bereavement facilities were a considerable improvement for families;
- The improvement board, located in the department, was observed to be well used with the views and voices of staff being considered and heard.
- Staff reported members of the executive team to be highly visible and supportive during times of surge.
- Dedicated time to provide and to access training was welcomed by junior doctors across the department.
- The CQC observed good working relationships between ED staff and ambulance staff.
- Staff reported they were able to raise concerns to the management team.
- Health professionals reported good multi-disciplinary working with positive relationships existing between doctors and nurses for example.

The Trust is currently rated as “requires improvement” overall and this latest inspection does not change the rating. The CQC required action against two regulations following the inspection:

Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect, and Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment. The actions required relating to these are:

- Ensure patients receive a timely assessment of their care needs and that a plan of care is established and delivered in line with national best practice.
- Ensure patients receive care and treatment in an environment which is fit for purpose and meets national standards.
- Ensure staff consistently utilise safety measures as determined by trust policy.
- Ensure the emergency department operates an effective and safe process for receiving and assessing patients who self-present to the department.
- Ensure staff abide by the trusts values and behaviours at all times, including ensuring the privacy and dignity or patients is maintained.
- Ensure medical equipment is checked and ready for use as defined by trust policies.

The Trust recognises, as outlined in the report, that there is more work to do and will continue to focus on ensuring the required improvements are made. A formal response will be provided to the CQC as requested. However it should be noted that the points above already form part of the Trusts current quality recovery plan and are overseen and managed formally, as described in the April report to HASC on this subject.

The Trust urgent care transformation programme is well underway, and will include building a new Emergency Department. This will help to improve patient flow and deliver a better experience for patients and staff.

The Trust has not yet received a further visit from the CQC to assess for themselves the impact of the actions taken to address S29A, and is expecting its routine full inspection later this year.

ENDS

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Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

Queen Alexandra Hospital
Cosham
Portsmouth
PO6 3LY
Tel: 023 9228 6000
Website: www.porthosp.nhs.uk

Date of inspection visit: 25 February 2019
Date of publication: 16/04/2019

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Urgent and emergency services	Not sufficient evidence to rate

Summary of findings

Letter from the Chief Inspector of Hospitals

This was a focussed, unannounced inspection of the emergency care service at Queen Alexandra Hospital. This inspection took place on 25 February 2019. We have not inspected all key lines of enquiry and so we have not issued any revised ratings of the urgent and emergency care service at this time.

Our key findings were:

We found there to be very limited clinical leadership of the emergency department, and in particular, the pit-stop area and ambulance reception area until the departmental Clinical Lead assumed control at approximately 16:00.

At times, we observed patients being handed between five different nurses with no clinical interventions occurring. These multiple handovers do introduce an element of risk for patients.

The nurse-in-charge was observed undertaking a range of task orientated activities including the physical movement of trolleys and patients; this distracted them from managing the emergency department and likely impacted on the poor flow across the emergency pathway.

Majors B lacked any noticeable senior clinical leadership; oversight of flow was by way of a band four associate practitioner (Nursing). Patients experienced delays in discharge because of a lack of suitably competent staff or the availability of equipment.

Flow through the pit-stop process was slow and at times became stagnated. There was confusion as to the purpose of the area with some patients receiving extended levels of care, again despite other patients waiting in the department for their treatment to commence. Again, there lacked any noticeable clinical leadership of the area which impacted on the smooth flow of patients through the emergency pathway.

The waiting room did not have sufficient seating to accommodate patients during peak times. Patients and visitors were observed standing for extended periods because of a lack of seats. We noted the streaming nurses to be competent at undertaking initial assessments. Patients did however experience delays in their care commencing, in part because of a congested emergency department. Patients also experienced delays in being initially assessed by the streaming nurse. There was a lack of robust assurance to support the effectiveness of the streaming pathway.

Hand hygiene practices and compliance remained poor with very limited hand decontamination taking place during the inspection.

There were occasions when the privacy and dignity of patients was not protected. During feedback we provided examples of occasions when nursing staff had failed to cover patients up; instead opting to half close cubicle curtains. Frail elderly patients were left for periods of time in Majors with no access to call bells, and left in unacceptable states of undress.

Patients were observed being moved through the department without being spoken to; staff routinely released the brakes on trolleys and started moving patients. Again, this was a common observation; it showed little in the way of positive communication between patients and staff.

However,

New bereavement facilities were a significant improvement on the facilities which had been found to be lacking at previous inspections.

Summary of findings

The improvement board, located in the department, was observed to be well used with encouraging signs the views and voices of staff were being considered and heard respectively. There was a sense amongst staff we spoke with of improvements in relationships between the trust leadership team and staff working in the emergency department. Staff reported members of the executive team to be highly visible and supportive during times of surge.

The introduction of dedicated training time was welcomed by junior doctors across the department. The protected rostered non-clinical time for consultants to provide dedicated training on a weekly basis will be of great benefit to trainee doctors.

The use of the Hospital and Ambulance Liaison Officer (HALO) to oversee and co-ordinate the arrival of ambulances during times of surge, and the working relationships between the local NHS ambulance trust and Portsmouth Hospitals NHS Trust seemed robust. We observed good working relationships between ED staff and ambulance staff. There was clear prioritisation of patients who remained “On-board” ambulances due to limited capacity in the emergency department.

The service maintained a risk register which recorded known risks and rated them according to their potential impact. The risk register reflected the risks spoken about by staff in the department. The risk register further acknowledged the challenges inspectors identified during the inspection. There was a sense the leadership team were more aware of the challenges they faced than was the case in the previous inspection.

A range of staff including doctors, nurses, support workers, administrative staff and representatives from the local NHS ambulance trust reported they were able to raise concerns to local the management team without fear of retribution. Staff told us they felt supported and were encouraged to be open and transparent. There was an appetite among staff to improve the quality of care provided in the department.

Health professionals reported good multi-disciplinary working with positive relationships existing between doctors and nurses for example.

Many staff described their work colleagues as their second family and told us they would not want to work anywhere else. This continued to be the case at this inspection despite the department having experienced very busy periods over the preceding weeks.

Dr. Nigel Acheson

Deputy Chief Inspector of Hospitals

Queen Alexandra Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Urgent and emergency services

Safe	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. The emergency department (ED) is open 24 hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with minor injuries that need prompt treatment, such as lacerations and suspected broken bones.

The emergency department is a recognised trauma unit. Major trauma patients are transported directly to the nearest major trauma unit.

The department has a four-bay resuscitation area, with one bay designated for children.There are two major treatment areas; majors A has 18 bays and three cubicles, majors B has six bays and four chairs (with a trolley for clinical examination). There is a separate 'pit stop' assessment area with six trolleys and four chairs. In the event that the pit stop area is full, up to six patients are accommodated in the corridor while they wait for assessment. One further corridor area is used when the department reaches capacity. There is a nine-bed emergency decision unit (EDU). This area comprises two four-bed bays and a single-bed side-room. The area is used for patients who are unlikely to require admission but who require short term observation or are waiting for test results. The unit is regularly used to accommodate patients with acute mental health problems who are waiting for assessment by a mental health practitioner or waiting for a mental health bed.

There is a sideroom designated for mental health practitioners to undertake mental health assessments. The unit also accommodates frail elderly patients. The minor treatment area has six treatment cubicles and two consultation rooms used by general practitioners to provide an urgent care service. This service operates from 8am to 11pm, seven days a week and sees patients who present with a condition which requires immediate treatment, but which can be carried out by a GP.

The emergency department has a separate children's treatment area with its own secure waiting room. This consists of an observed play area, a high dependency cubicle, an isolation room, five majors cubicles and four minors cubicles. This area is open from 7.30am until 2am, seven days a week. Outside of these hours, children are seen in the main (adult) area of the emergency department or they are taken directly to the children's assessment unit, located elsewhere in the hospital.

A purpose built Frailty Assessment Unit opened in January 2019. This facility provides ten care spaces for frail patients, who are unlikely to require admission, but may require multi-disciplinary input.

A new, purpose built, bereavement suite has been in use since January 2018. This suite provides a dedicated and private space for relatives to say farewell to their loved one and grief in private.

Urgent and emergency services

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

Our key findings were:

At times, we observed patients being handed between five different nurses with no clinical interventions occurring. These multiple handovers do introduce an element of risk for patients.

We found there to be very limited clinical leadership of the emergency department, and in particular, the pit-stop area and ambulance reception area until the departmental Clinical Lead assumed control at approximately 16:00.

The nurse-in-charge was observed undertaking a range of task orientated activities including the physical movement of trolleys and patients; this distracted them from managing the emergency department and likely impacted on the poor flow across the emergency pathway.

Majors B lacked any noticeable senior clinical leadership; nursing oversight was by way of a band four health professional who was not able to administer intravenous medicines. Patients experienced delays in discharge because of a lack of suitably competent staff or the availability of equipment.

Flow through the pit-stop process was slow and at times became stagnated. There was confusion as to the purpose of the area with some patients receiving extended levels of care, again despite other patients waiting in the department for their treatment to commence. Again, there lacked any noticeable clinical leadership of the area which impacted on the smooth flow of patients through the emergency pathway.

The waiting room did not have sufficient seating to accommodate patients during peak times. Patients and visitors were observed standing for extended periods because of a lack of seats. We noted the streaming nurses to be competent at undertaking initial assessments. Patients did however experience delays in their care commencing, in part because of a congested emergency department. Patients also experienced delays in being initially assessed by the streaming nurse. There was a lack of robust assurance to support the effectiveness of the streaming pathway.

Hand hygiene practices and compliance remained poor with very limited hand decontamination taking place during the inspection.

There were occasions when the privacy and dignity of patients was not protected. During feedback we provided examples of occasions when nursing staff had failed to cover patients up; instead opting to half close cubicle curtains. Frail elderly patients were left for periods of time in Majors with no access to call bells, and left in unacceptable states of undress.

Patients were observed being moved through the department without being spoken to; staff routinely released the brakes on trolleys and started moving patients. Again, this was a common observation; it showed little in the way of positive communication between patients and staff.

However,

New bereavement facilities were a significant improvement on the facilities which had been found to be lacking at previous inspections.

The improvement board, located in the department, was observed to be well used with encouraging signs the views and voices of staff were being considered and heard respectively. There was a sense amongst staff we spoke with of improvements in relationships between the trust leadership team and staff working in the emergency department. Staff reported members of the executive team to be highly visible and supportive during times of surge.

The introduction of dedicated training time was welcomed by junior doctors across the department. The protected rostered non-clinical time for consultants to provide dedicated training on a weekly basis will be of great benefit to trainee doctors.

The use of the Hospital and Ambulance Liaison Officer (HALO) to oversee and co-ordinate the arrival of ambulances during times of surge, and the working relationships between the local NHS ambulance trust and Portsmouth Hospitals NHS Trust seemed robust.

Urgent and emergency services

We observed good working relationships between ED staff and ambulance staff. There was clear prioritisation of patients who remained “On-board” ambulances due to limited capacity in the emergency department.

Are urgent and emergency services safe?

Not sufficient evidence to rate

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

Environment and equipment

- We had previously reported crowding within the ambulance entrance posed a risk to the safety of patients. At this inspection, the emergency department was frequently crowded.We saw patients frequently queued in the corridor inside the ambulance entrance. This was a confined space and frequently became congested, hampering the movement of patients, staff and equipment. The area was not designed or equipped for patients. There were no call bells or piped oxygen in this area. Patient flow across the emergency department was poorly managed, in part because of the multiple tasks being undertaken by the designated nurse-in-charge which distracted them from providing a command-and-control ability, and also because of the poor layout of the department hindering effective communication. The trust acknowledged the environment was not suitable for providing modern emergency healthcare. The trust reported they had been successful in securing capital funding to redevelop the emergency care department. This was being driven via the Portsmouth Hospitals NHS Trust Emergency Floor Reconfiguration Project.
- The emergency department comprised of a four-bay resuscitation area, with one bay designated for children.There were two major treatment areas; majors A which had 18 bays and three cubicles; and majors B which had six bays and four chairs (with a trolley for clinical examination). There was a separate ‘pit stop’ assessment area with six trolleys and four chairs. The department had a a nine-bed emergency decision unit (EDU) which comprised of two four-bed bays and a single-bed side-room. The area was used for patients who were unlikely to require admission but who required short term observation or were waiting for test results. The EDU was regularly used to accommodate patients with acute mental health problems who were waiting for assessment by a mental health practitioner or waiting for a mental health bed. A designated room

within the EDU was used to accommodate patients with acute mental health problems was noted to be ligature free. Staff had completed environmental risk assessments for the rest of the department to reduce the likelihood of a patient being able to attempt suicide by way of the use of a ligature point. The risk of suicide by way of a ligature point was reported on the department's risk register. A range of risk assessments and dynamic risk management strategies were used to manage the risk which was rated as moderate on the risk register.There was good compliance noted with the completion of mental health risk assessments during the audit period of April 2018 to January 2019. Compliance was observed to be at or above 98% each month, with 100% compliance achieved in September, November and December 2018.

- Point of care testing was available within the emergency department enabling staff to reach clinical decisions without delay. For example, flu testing equipment was frequently used in the ED resulting in confirmed cases of flu being diagnosed within 30 minutes. This enabled staff to better manage patients and to isolate them where this was clinically indicated.
- The children's emergency department was co-located but physically separate, providing a secure area, which was not overlooked by adult patients and visitors. Concerns had been raised at governance and quality meetings regarding children being cared for in the adults' department after the children's department closed at night. Consequently, the minors area was identified as the most appropriate place to manage children out of hours, except for those patients who required enhanced levels of care; in those instances, children were moved to the dedicated children's resuscitation bay, or their care expedited to the children's inpatient service.
- Resuscitation equipment was not always checked in line with trust policy. Full weekly checks had been completed on 9, 25 and 30 January, 13, 15 and 20 February for one trolley located in major's B; the trolley had not had daily checks completed on 6, 7, 8, 10, 19, 24 or 26 February 2019.
- Hand hygiene practices and compliance remained poor with very limited hand decontamination taking place during the inspection.

Assessing and responding to patient risk

- Patients who self-presented to the emergency department were seen on arrival by a registered nurse, known as the navigator. Their role was to quickly assess patients (before they were booked in by receptionists) in order to direct them to the most appropriate area of the emergency department. This may be the minor or major treatment areas or the GP-led urgent care area when a GP was present to provide this service.
- The waiting room had been 'divided' by the use of red and blue floor covering to separate those patients who were waiting to be assessed, and those who had been assessed and were waiting for treatment. There was signage to direct patients on arrival to sit in the area designated 'red', where they would wait to be seen by the navigator. During our observation of this process we saw the signs were not sufficiently prominent. Patients and visitors were unsure what to do or where to sit when they entered the department and many went directly to the reception desk, where they were re-directed, or they asked other people in the waiting room.This was a common occurrence and was something we had previously reported on following our inspection of the emergency department in 2018. We observed the result of such a confusing and poorly signposted reception area was that patients were often not seen in time order and some patients in the blue area, missing the streaming process altogether, resulting in further delays to the commencement of their initial clinical assessment.
- The navigator's base was a glass-screened room, which enabled the nurse to observe the waiting room. This allowed them to quickly assess whether a patient required urgent attention**.** However, the positioning of the 'red' seating, just inside the entrance, meant that patients could not be easily observed by either the navigator or the reception staff. We were told that when more than four patients were waiting to be assessed, or if the initial assessment wait was longer than ten minutes, an additional nurse would be moved from the major treatment area to support the process. There was variation as to when this escalation protocol was applied, based on the clinical experience of the navigator. For example, we observed the waiting room at approximately 5.30 pm at which time six patients were seated in the red area waiting to see the navigator. At no time did the navigator escalate the queue which therefore meant patients were required to wait their

turn, and longer than 15 minutes before being assessed by the navigator. We observed the navigation process for a period of one hour during which three patients waited longer than fifteen minutes, with two patients waiting 20 minutes before being called through. The navigator was noted to be away from the navigation cubicle for a period of seven minutes during our observation. We asked the trust to provide us with data reflecting the time patients waited from arrival to initial assessment however they were unable to do so because of the nature of the patient pathway. Because patients were required to wait to see the navigator before they were booked in, there was no robust oversight of the time to initial assessment standard.

- Navigator nurses undertook comprehensive assessments of patients including a quick sequential organ failure assessment (qSOFA) and physical observations if these were clinically indicated. Navigator nurses were empowered to sign post patients to more appropriate clinical settings such as primary care or minor injury units if their presenting condition could be effectively managed outside of the emergency care pathway. We observed patients being appropriately signposted during the inspection. Patients identified by the navigator as requiring assessment and treatment in the major treatment area were directed/escorted there immediately or, if the pit stop was full, asked to sit in one of four numbered chairs at the back of the waiting room, where they could be easily observed by staff.
- We had previously reported the streaming process had not been working efficiently or effectively, especially when the department was busy. The trust provided draft standard operating procedures following our previous inspection in 2018; these had since been ratified at the time of this recent inspection. However, governance oversight of the waiting room remained limited. There was evidence of an awareness of the challenges faced by the department during times of surge activity. For example, there was a recognition of patients experiencing long waits in the reception area, as referenced in clinical governance minutes. Whilst high risk patients were relocated to the minor's area if clinical assessments were required and there was no capacity in the pit-stop or majors area, there appeared little other monitoring of the waiting room once patients had seen the navigator. This meant patients at risk of deterioration may not be identified in a timely way.

Ambulance handovers greater than 60 minutes

- We had previously reported frequent delays in the handover of patients by ambulance staff to emergency department staff. The emergency department was working with the ambulance service to improve the handover process. This remained the case during this recent inspection.
- The proportion of ambulance handovers delayed more than 60 minutes has been worse than England since the end of January 2019. From 28 January to 10 February, 12.8% of patients conveyed by ambulance had handover delays over 60 minutes, compared to England overall which had 2.9%. 17.4% of ambulance handovers were delayed by more than 60 mins between 4 to 17 Feb 2019. The proportion was statistically worse than the England rate, which was 2.8% in this period.
- A review of the February 2019 integrated performance report suggested there had been some improvements in the number of patients held on ambulances for periods longer than 60 minutes between April and July 2018. However, performance then deteriorated with a peak of patient holds noted from August 2018 through to December 2018. In December 2018 more than 600 patients were held for more than 60 minutes over the month.
- Staff told us that recent changes to general practitioner referral patterns had resulted in increased hospital bed occupancy which was impacting on the ability to move patients through the emergency department. This was reflected in the integrated performance report for February 2019 which showed an increasing trend in bed occupancy from December 2018 on-wards. As a result of poor departmental flow, staff reported patients were often held on ambulances outside the emergency department because of a lack of capacity to receive the patient in to the department. This occurred during the inspection when, shortly after our arrival, six patients were being held on ambulances outside the emergency department. At the 1 pm bed meeting four ambulances were holding their patients, and the ED corridor was full with patients who were waiting for clinical space to be created. There had been 107 reported four hour breaches (national standards require 95% of patients who attend an emergency department to be admitted, transferred or discharged within four hours from arrival) and one patient had been in the department for fourteen hours because of a lack of inpatient beds. At

approximately 4.20 pm, three patients remained on ambulances with one patient having been held for over one hour whilst a second patient had been held for 56 minutes.

- When patients were held on ambulances, a hospital and ambulance liaison officer (HALO) and a nurse from the ED worked collaboratively. Patients were seen to be assessed by a dedicated ED nurse as soon as the ambulance arrived in to the ambulance bay. Once a cubicle became available, patients were offloaded, with the sickest patients given priority. The nurse allocated to the ambulance bay continued to monitor patients; where a patient's condition worsened, the ambulance bay nurse liaised with medical colleagues to review the patient and to expedite the care of the patient as clinically indicated. This ensured the sickest patients were prioritised and treated without delays to their care or treatment.
- We were told that when more than six patients were held on ambulances, senior staff would activate an internal critical incident which led to patients being "cohorted" in the corridor adjacent to the nursing station located at the ambulance entrance. We observed this occur during the inspection. We noted the process resulted in a congested corridor. Patient privacy and dignity was compromised; there was little in the way of clinical leadership and confusion among nursing staff as to which patient posed the greatest clinical risk. On one occasion, we observed a patient's care being transferred between five different nurses.
- Nationally reported data suggested that in December 2018 the median time to initial assessment for patients conveyed by ambulance was 220 minutes compared to the England average of 9 minutes. The trust's median time was much longer than England for most of 2018. The trust's time ranged from 183 to 312 minutes compared to the England range of 7 to 9 minutes. However, further queries with the trust confirmed the data reported nationally was incorrect and that this was being resolved between the trust and their information technology service provider. The trust reported consistently good performance against the time to initial assessment standard. Between January 2018 and January 2019 the monthly median times to initial assessment for patients conveyed via ambulance ranged between 3 and 7 minutes which was better than than England range reported above.
- There were systems in place for the ongoing monitoring of risks to patients in the emergency department so that staff could identify seriously ill and deteriorating patients. The emergency department used a nationally recognised 'track and trigger' system to identify critical illness or deteriorating patients. For patients arriving by ambulance, the receiving nurse was required to record patients' observations, as recorded by the ambulance crew, and undertake a first set of emergency department observations; these observations were inputted in to the computer system which automatically generated a score. These scores were linked to escalation protocols which were observed to be used during the inspection. Staff could view the most recent early warning score clearly for each patient on the front screen of the patient administration system.
- Staff completed computer based risk assessments for the majority of patients who presented to the emergency department. The emergency department safety checklist prompted staff to complete a range of assessments and acted as a safeguard for ensuring specific tasks were completed for patients. For example, where patients had had an electrocardiogram (ECG), the checklist prompted nursing staff to confirm the ECG had been reviewed by a doctor or other senior clinical decision maker. Additionally, the safety checklist prompted staff to consider the holistic needs of patients, including whether the patient had a learning disability, was living with dementia, or if the patient was suffering from an illness which required them to take time sensitive medicines, for example, those with insulin-dependent diabetes or Parkinson's disease. Audit data provided by the trust suggested some variability in the completion of the safety checklist with compliance being reported as:

1. 95% - November 2018
2. 97% - December 2018
3. 81% - January 2019

- During the inspection we reviewed ten sets of medical records. Observations were completed frequently and risk assessments were completed. However, in one case, we noted that a frail elderly patient remained on a trolley for more than six hours despite being at risk of skin damage.
- The emergency department participated in a commissioning for quality and innovation (CQUIN) programme related to the management of patients with

possible sepsis. Between August and December 2018, 100% of patients with possible sepsis were screened upon arrival to the ED or other "direct admission" areas. The CQUIN required that at least 50% of those patients received antibiotics within 60 minutes from time of diagnosis; this target was achieved and exceeded during each month of the audit period. However, commentary in the February 2019 integrated performance report alluded to an overall deterioration in performance for the administration of antibiotics within an hour for the emergency department during the previous financial quarter.

Nurse staffing

- The emergency department was funded for an establishment of 163 full time equivalent registered nursing posts. At the time of the inspection, the vacancy rate was reported as 6.5%. This compared positively against the wider trust vacancy rate for registered nurses of 12.3%.
- The department used a range of band three care support workers and band four Associate Nurse Practitioners (Nursing) who worked alongside registered nurses. At the time of the inspection, the department was funded for 38 full time equivalent support workers. 41.3 were in post, producing an over-established position of -8.6%.
- There were processes in place for ensuring the department was staffed safely and Matrons met with care group managers and divisional nursing directors to review rosters and to predict any requirements for temporary staffing. Staff told us that regular bank and agency staff were used, so they were familiar with the department. There was a local induction checklist which was completed by temporary staff and records were held in the department. Between 30 December 2018 and 17 February 2019 a total of 24.8% of registered nursing shifts which were placed out for temporary staffing remained unfilled. During the same period, 22.7% of non-registered nursing shifts remained unfilled. Where shifts remained unfilled, we observed staff being moved from other departments such as the acute medical unit to help support the emergency department during periods of surge. Daily staffing huddles were held to consider the activity of the department in real-time and to identify any additional staffing requirements based on patient demand and department capacity
- A total of 22 nurses and six support workers were deployed across the emergency department 24 hours a day. Three nurses were deployed to manage the resuscitation area which was in line with national recommendations. The resuscitation area was further supported by a senior clinician 24 hours a day. We reviewed a range of rota's which showed some variation in the filling of shifts which was consistent with the data provided by the trust. We noted the layout of the department meant additional staff were required to ensure there were sufficient numbers of staff available to meet patient needs.
- The department was staffed with a nurse-in-charge who did not take a patient case load. However, during the inspection we observed the nurse in charge undertaking duties which distracted them from leading the department, including the movement of trolleys, beds and equipment.
- The pit-stop area received patients who were conveyed by ambulance and also those patients who self-presented to the trust and who had been assessed by the streaming nurse as requiring rapid assessment and treatment. The area was staffed with three registered nurses and one support worker. We noted the support worker was co-ordinating flow within the area whilst nursing staff provided care and treatment to patients. This meant that at times, there were delays in communication between the nurse in charge and the Pit-stop as the support worker was required to liaise with nursing staff to determine which patients were most appropriate for being transferred out of the pit-stop area. A band four Associate Practitioner (Nursing) was observed to co-ordinate flow through Majors B.
- The trust reported the following levels of basic life support training:

1. Unregistered Band 2 - 65%
2. Nursing (registered, Band 5 or above) -75%

- 100% of relevant staff had completed paediatric advanced life support training.

Medical staffing

- The trust reported a funded substantive consultant workforce of 16.6 full time equivalent establishment. At the time of the inspection, there were 18.8 full time equivalent consultants in post.

Urgent and emergency services

- There was senior medical presence in the emergency department for 24 hours a day, seven days a week. Consultants were present for 16 hours a day, which is in line with the Royal College of Emergency Medicine's recommendations. There were 2.5 whole time equivalent (FTE) consultants in children's emergency medicine, in addition to five dual-trained (adults and children) consultants and a specialist trainee.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed. We observed early senior involvement in the treatment of patients throughout our inspection.
- There were gaps reported in the junior doctor workforce. The trust reported a vacancy rate of 31.2% against the budgeted junior doctor establishment. To mitigate against any staff shortages, locum doctors were sourced to back-fill rota gaps. Board rounds occurred daily during which medical and nurse staffing challenges were both discussed and actions identified.
- Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and always accessible.
- 98% of medical staff had completed basic life support training. 98% of relevant medical staff had completed advanced trauma life support or other equivalent course.

Are urgent and emergency services caring?

Not sufficient evidence to rate

Compassionate care

- During clinical consultations, staff were observed speaking to patients with compassion and respect. Staff took time to locate appropriate clinical areas to consult with and assess patients, compared to undertaking care in corridors as had been previously observed.

However,

- There were occasions when the privacy and dignity of patients was not protected. During feedback we provided examples of occasions when nursing staff had failed to cover patients up; instead opting to half close cubicle curtains. Frail elderly patients were left for periods of time in Majors with no access to call bells, and left in unacceptable states of undress.Patients were observed being moved through the department without being spoken too; staff routinely released the brakes on trolleys and started moving patients without communicating with the patient. Again, this was a common observation; it showed little in the way of positive communication between patients and staff.
- There was little consideration given to the individual needs of those patients who were cohorted in corridors. For example, one patient with learning disabilities became increasingly distressed due to being overly stimulated whilst they were held in the corridor for an extended period of time. A second, frail and confused elderly patient who was offloaded from the ambulance subsequently started to wander; the patient was initially offered a chair but an increase in wandering meant a number of staff were required to support the patient so they did not fall due to being unsteady on their feet. Staff subsequently located a trolley for the patient however they remained in the corridor for an extended period of time.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Not sufficient evidence to rate

As this was a focused inspection we have not inspected the whole of this key question and the rating has not been updated.

Access and flow

- Although the trust reported their operational status using nationally defined characteristics, some local leaders demonstrated a limited awareness of the system used. Operational Pressures Escalation Level (OPEL) provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving

organisations unable to deliver comprehensive care. The nurse-in-charge and local operations manager both reported they did not know what OPEL status they were operating at, in part because they had not yet attended the operational bed meeting. The Chief Operating Officer later reported the trust was at operational pressures escalation level 3. This meant the local health and social care system was experiencing major pressures which compromised patient flow with activity likely to increase further. A range of admission avoidance schemes and direct admission protocols had been developed to help alleviate pressure on the emergency department. A frailty intervention team was present seven days a week and had access to a new frailty unit. This enabled the team to assess, support and discharge frail patients more quickly from the emergency department.

- A range of acute medical pathways had been established to help improve patient flow across the emergency department. A consultant-led telephone advice line had been established approximately five years ago. The trust reported that less than half of all calls received by the help-line resulted in a patient being referred to the ED or other clinical in-patient setting. Without the help-line, staff reported those cases discussed with consultants would have historically resulted in patients being sent to the acute care setting for on-going care and treatment. Staff spoke positively about the help-line as it helped keep small but consistent numbers of patients from being admitted to hospital.
- A re-launch of the clinically-led admissions policy was in the process of being implemented at the time of the inspection which would allow ED staff to directly admit patients to appropriate in-patient beds, thus helping improve flow across the emergency care pathway.
- In December 2018, the trust's monthly median total time in A&E for all patients was 164 minutes compared to the England average of 158 minutes. The trust median total time in A&E has been similar to the England overall since January 2018.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From January 2018 to December 2018 the trust failed to meet the standard and performed worse than the England average.
- In December 2018, 71.4% of patients spent less than four hours in the Major Type 1 departments at the trust. This was much worse than England's target 95% and worse than the England overall of 79.3%.
- 22% of patients waited between 4-12 hours from the decision to admit to being admitted. This was similar to England overall but better than December 2017 which was 47% at the trust.
- 0 patients waited more than 12 hours between June and December 2018 going into the winter period.
- The recommended time patients should wait from time of arrival to receiving treatment should be no more than one hour. In Dec-18 the median time to treatment was 51 minutes, which is shorter than the recommended time and the England average of 60 minutes. The trust median time was generally shorter than the England overall time for all of 2018.
- Senior members of the trust leadership team reported an unprecedented increase in the level of activity experienced by the emergency department in the two week period prior to our inspection. Information from the February 2019 integrated performance report made reference to an increase in the number of ambulances conveyed to the trust during January 2019 (4,084 versus 3,501 for the same period in 2018 - an increase of 16.6%). Overall ED attendances were reported to have increased by 8.6% when compared to January 2018. The increase in patient activity, as well as the number of patients referred in to the organisation from general practitioners and other community and primary health care professionals was reported to have increased the number of patients directly admitted to the hospital. This had led to increased bed occupancy rates, therefore impacting on the flow across the emergency care pathway.
- We had previously reported the layout of the department had been reconfigured over time to create more capacity but the size of the department and physical separation of the two major treatment areas did not readily allow for good communication. Senior staff had radio contact with each other but communication remained challenging. This remained

the case at this inspection. Whilst each area had an assigned health professional who was "In charge" of that clinical area, there was disjointed and often poor communication between the nurse-in-charge of the entire department; the lead consultant; and those in charge of the sub-sections of the department. This impacted on the ability of the team to manage departmental flow.

- Cubicle spaces were often occupied with patients who were waiting care and treatment. For example, one patient waited over five hours before they received the appropriate level of care and subsequently discharged. Another patient was delayed for discharge because there was no bladder scanner available; we observed the scanner being moved around the department. This was another example of how the footprint impacted on the ability of staff to deliver effective and timely care. Flow through majors B was poor, with patients often waiting for diagnostic results to become available before treatment decisions could be made. This was despite there being sufficient capacity in the emergency decision unit to accommodate such patients. The lack of senior clinical decision making was likely to be impacting on the ability of the wider medical and nursing teams to recognise early those patients who could be transferred to more appropriate clinical settings within the emergency pathway as compared to waiting in a majors cubicle whilst patients were held in the corridor.

Are urgent and emergency services well-led?

Not sufficient evidence to rate

As this was a focused inspection we have not inspected the whole of this key question and therefore have not updated the rating.

Leadership

- At this inspection, staff were proud of the progress they had made however a small contingent of senior staff continued to remain hostile and uncooperative towards the inspection team. This sense of animosity and hostility suggested further work was required in regards to action 5.3 of the wider ED improvement plan. This action described the need for a stronger and more united leadership team within the ED. Our observations on the day of the inspection was that the department continued to lack a sense of collaborative clinical and nursing leadership.
- We observed that once the ED clinical lead took control of the department at approximately 4 pm, flow was generated across the department; the ambulance corridor was decompressed and patients who had remained in the department for longer than was clinically indicated were assessed, treated and discharged.
- We were not assured that all clinicians in the department had the same leadership skill set and understanding as was demonstrated by the clinical lead; the development of the ED improvement plan correctly identified the need for further work in this regards. We noted all actions related to this specific point of the ED improvement plan had been completed. We have set out must do actions (Musts") within this report which suggests this area is reviewed to determine the effectiveness of the actions listed as complete.

Vision and strategy for this service

- We previously reported that the overall vision for the service was to develop an urgent care floor or ‘one stop shop’ for all unscheduled care. Plans had been developed which were captured in the Portsmouth Hospitals NHS Trust Emergency Floor Programme. This was a multi-agency approach to addressing the continued challenges faced by the local health economy of providing an effective emergency care programme. Investment had been secured which meant further plans could now be developed to implement a capital build at Queen Alexandra Hospital. Most staff we spoke with seemed to be appraised of this vision and early plans had been discussed at governance and quality meetings. A programme team and appropriate governance arrangements were in the process of being established at the time of the inspection, with the intention of delivering the new strategy.
- Daily board rounds were attended by colleagues from across the emergency department and acute medical unit. Current ED activity, staffing challenges and bed requirements were all discussed. Acute medicine board rounds were also undertaken daily during which ED capacity was further discussed and actions developed to help reduce pressures on the emergency department

where possible. We asked the trust to provide us with data to show how they were monitoring compliance with the trust's professional standards. Due to IT challenges, the trust was not able to report response times from speciality, once referrals had been made. The trust was working to resolve this during 2019.

Governance, risk management and quality measurement

- The service maintained a risk register which recorded known risks and rated them according to their potential impact. The risk register reflected the risks spoken about by staff in the department. The risk register further acknowledged the challenges inspectors identified during the inspection. There was a sense the leadership team were more aware of the challenges they faced than was the case in the previous inspection. Risks across the emergency care pathway had been considered and mitigating actions put in place for known issues. However, there remained risks for which mitigations were poorly thought through and implemented. This included the lack of robust clinical oversight and co-ordination of the waiting room and respective streaming processes. There was some "yo-yo" compliance against the completion of the ED safety checklist which raised concerns over the ability of the department to deliver sustainable change. Gaps in the checks of equipment had gone unnoticed suggesting some weaknesses in existing assurance mechanisms. The concept of monitoring best practice against privacy and dignity was poorly considered.
- Governance meetings occurred monthly. Consideration was given to standing agenda items including complaints, incidents, local audit outcomes, local risks, operational concerns, safeguarding concerns, clinical effectiveness and the ED quality improvement plan. Attendance at the meetings was consistent with representation from nursing, medical and governance professionals. Outcomes of meetings were displayed across the department. Incidents were reviewed and lessons learnt were also displayed in all clinical areas, therefore raising the awareness of any changes to practice.

Culture

- A range of staff including doctors, nurses, support workers, administrative staff and representatives from the local NHS ambulance trust reported they were able to raise concerns to local the management team without fear of retribution. Staff told us they felt supported and were encouraged to be open and transparent. There was an appetite among staff to improve the quality of care provided in the department.
- Health professionals reported good multi-disciplinary working with positive relationships existing between doctors and nurses for example. We had previously reported teamwork, peer support and camaraderie as being the reasons why many staff enjoyed coming to work. Many staff described their work colleagues as their second family and told us they would not want to work anywhere else. This continued to be the case at this inspection despite the department having experienced very busy periods over the preceding weeks.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

Ensure patients receive a timely assessment of their care needs and that a plan of care is established and delivered in line with national best practice.

Ensure patients receive care and treatment in an environment which is fit for purpose and meets national standards.

Ensure staff consistently utilise safety measures as determined by trust policy.

Ensure the emergency department operates an effective and safe process for receiving and assessing patients who self-present to the department.

Ensure staff abide by the trusts values and behaviours at all times, including ensuring the privacy and dignity or patients is maintained.

Ensure medical equipment is checked and ready for use as defined by trust policies.

Action the hospital SHOULD take to improve

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Dignity and respect** 10.—(1)Service users must be treated with dignity and respect. (2)Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— (a)ensuring the privacy of the service user; (c)having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user. The privacy and dignity of patients held in the ambulance corridor was not always protected. Staff did not routinely speak to, or inform patients of their intention to transfer the patient to other parts of the emergency department. A patient was observed to be in a state of undress and without access to a call bell. Staff did not respond to meet this individuals needs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment** 12.—(1)Care and treatment must be provided in a safe way for service users. (2)Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

This section is primarily information for the provider

Requirement notices

(a)assessing the risks to the health and safety of service users of receiving the care or treatment;

(b)doing all that is reasonably practicable to mitigate any such risks;

(c)ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

(d)ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

(e)ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(h)assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

Staff did not routinely decontaminate their hands before and after patient contact.

Resuscitation equipment was not routinely checked in accordance with trust policies.

Staff with the right skills and competence were not always deployed effectively across the department. This meant patients experienced delays in receiving the right level of care or treatment.

Risks associated with the management of patients in the waiting room and the ambulance corridor were not always considered or effectively mitigated against.

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	14 May 2019
Report Title:	Proposals to Develop or Vary Services
Report From:	Director of Transformation & Governance

Contact name: Members Services

Tel: (01962) 845018 **Email:** members.services@hants.gov.uk

Purpose

1. The purpose of this report is to alert Members to proposals from the NHS or providers of health services to vary or develop health services provided to people living in the area of the Committee. At this meeting the Committee is receiving updates on the following topics:

   a) Portsmouth Hospitals Trust: Spinal Surgery Service Implementation update

   b) Southern Health NHS Foundation Trust: Update on Temporary Closure of Older People's Mental Health Ward (Beaulieu)

   c) Southern Health NHS Foundation Trust: Planned Changes to West Hampshire Learning Disability Service

Recommendations

2. Summary of recommendations; the recommendations for each topic are also given under the relevant section below, regarding each item being considered at this meeting:

3. *Portsmouth Hospitals Trust: Spinal Surgery Service Implementation Update*
   That the Committee:
   - Note the update that the service was transferred from Portsmouth Hospitals NHS Trust (PHT) to University Hospital Southampton NHS Foundation Trust (UHS) on 31 October 2018 as planned and any recorded issues addressed and/or resolved.

4. *Southern Health NHS Foundation Trust: Update on Temporary Closure of Older People's Mental Health Ward (Beaulieu)*
That the Committee:
   - Note the update including the planned re-opening of the ward on 3 June 2019 with a small reduction in beds (17 to 14 beds) after a full refurbishment and recruitment of a new team.
   - Consider whether any further update is required e.g. regarding monitoring of demand and availability of inpatient beds

5. *Southern Health NHS Foundation Trust: Planned Changes to West Hampshire Learning Disability Service*
That the Committee:
   - Consider whether the proposed move constitutes a substantial change.
   - Consider whether to support the proposed move as in the interest of service users and the local health system.
   - Consider whether to request a further update.

Summary

6. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

7. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services (version agreed at January 2018 meeting). This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, and takes account of key criteria for service reconfiguration identified by the Department of Health.

8. This Report is presented to the Committee in three parts:

   a. *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS or providers of health services to substantially change or vary health services.

   b. *Items for monitoring:* these allow for the monitoring of outcomes from substantial changes proposed to the local health service agreed by the Committee.

   c. *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

9. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire, and to support health and social care integration, and therefore assist in the delivery of the Joint Health and Wellbeing Strategy and Corporate Strategy aim that people in Hampshire live safe, healthy and independent lives.

Items for Monitoring

10. **Portsmouth Hospitals Trust: Spinal Surgery Service Implementation Update**

Context

11. The HASC last received an update at the September 2018 meeting and requested an update on implementation of the service move for May 2019. A report providing an update has been provided, see appendix.

Recommendations

12. That the Committee:

Note the update that the service was transferred from Portsmouth Hospitals NHS Trust (PHT) to University Hospital Southampton NHS Foundation Trust (UHS) on 31 October 2018 as planned and any recorded issues addressed and/or resolved.

13. **Southern Health NHS Foundation Trust: Update on Temporary Closure of Older People's Mental Health Ward (Beaulieu)**

Context

14. Beaulieu Ward, based at Western Community Hospital (WCH), Southampton, has been temporarily closed for six months from November 2018 onwards due to staffing issues and challenges with the environment. The HASC last received an update at the January 2019 meeting and requested an update for May 2019. A report providing an update has been provided, see appendix.

15. The update indicates that the ward will reopen to admissions to older people with mental health needs on 3 June 2019 but with a small reduction in beds (17 to 14 beds).

Recommendations

16. That the Committee:

a) Note the update including the planned re-opening of the ward on 3 June 2019 with a small reduction in beds (17 to 14 beds) after a full refurbishment and recruitment of a new team.
b) Consider whether any further update is required e.g. regarding monitoring of demand and availability of inpatient beds

Items for Information

17. **Southern Health NHS Foundation Trust: Planned Changes to West Hampshire Learning Disability Service**

Context

18. Due to the enduring logistical challenges in regard to the location and the impact on the level of care, the West Hampshire Learning Disability team are proposing to move services from Totton Hub (in Totton) and Hampshire House (in Eastleigh) to Tatchbury Mount (in Calmore) this May/June. Staff and service users will be asked for feedback before and after the move to further improve access. A report providing a briefing on the proposal has been provided, see appendix.

Recommendations

19. That the Committee:

a) Consider whether the proposed move constitutes a substantial change.

b) Consider whether to support the proposed move as in the interest of service users and the local health system.

c) Consider whether to request a further update.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Other Significant Links

Links to previous Member decisions:	
Title	Date
Proposals to Vary Services	18 September 2018
Proposals to Vary Services	16 January 2019
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

Hampshire Health and Adult Social Care Select Committee
14 May 2019

Portsmouth Hospitals NHS Trust update

Portsmouth Hospitals NHS Trust (PHT) is providing updates to the Health and Adult Social Care Select Committee on the following issue of interest:

Transfer of Elective Spinal Service from Portsmouth Hospitals NHS Trust

- Health and Adult Social Care Select Committee members discussed the proposed transfer and community engagement in relation to the Elective Spinal Service from Portsmouth Hospitals NHS Trust to University Hospital Southampton NHS Foundation Trust at their previous meeting held in September 2018. This paper provides an update on the transition of services which took place on the 31 October 2018.

Transfer of Elective Spinal Service from Portsmouth Hospitals NHS Trust

As members are aware, the proposal to transfer the Elective Spinal Service from Portsmouth Hospitals NHS Trust (PHT) to University Hospital Southampton NHS Foundation Trust (UHS) was discussed at the Health and Adult Social Care Select Committee meeting held in September 2018. The Committee had previously agreed that the proposal did not constitute a substantial service change and that they were satisfied with the level of engagement carried out with local people prior to the transfer of service.

Committee members requested an additional update on the transition of services and any issues arising from the change.

The service transferred from PHT to UHS as planned on 31 October 2018. As a result, 154 patients from PHT were transferred to UHS and a further 91 patients were referred to community care provided by Solent NHS Trust following clinical triage.

PHT has retained ongoing communications with UHS and Solent NHS Trust following the transfer of services and, while some issues have been recorded, these have now been addressed and/or resolved:

- The original cohort of patients were reviewed by Solent NHS Trust, and PHT was advised where each patient was to be sent for treatment. While the majority of patients were informed in a timely manner, some patients experienced a slight delay. These were patients who were declined by UHS as community care was more appropriate for their needs, or were out of area. All of these patients and their GPs have now been informed in writing and referred to their local musculoskeletal service where appropriate.
- As a result of the increased number of patients being referred to community care, the community service reported to PHT that additional funding would be required. This was referred directly to commissioners who invested an additional £33,000 into the community service.
- UHS reported that one patient was not immediately referred to an appropriate service as they were not recorded on an appropriate waiting list. This has now been rectified and checks completed to ensure there were no further patients outstanding.
- PHT is not aware of any specific patient feedback or concerns.

ENDS

Southern Health
NHS Foundation Trust

02 May 2019

HASC Update: The re-opening of Beaulieu ward

This paper provides an update on the plans to re-open Beaulieu Ward, based at The Western Community Hospital, Southampton, which was temporarily closed for six months from November 2018 due to staffing issues and challenges with the environment.

We are pleased to inform you that Beaulieu Ward will now be reopening on Monday 3rd June.

The ward was originally meant to re-open in May and we had set the provisional date of 13 May for this. Even though we still aim to complete the works to the environment by this date, we want to ensure that the ward is clean and clinically safe before we accept any patients.

Once building work to the ward is complete, the ward will undergo a thorough deep clean and all the necessary procedures to ensure that it's fully ready to accept patients. During this time we will also be working closely with the patients, and their families, to ensure they have a smooth transition when being repatriated back onto the ward.

The reason we have chosen to re-open the ward on 3 June is because we are dependent on external suppliers to complete a thorough deep clean of the ward to a high enough standard for our patients. We are aware that some companies have reduced hours over the bank holiday weekend and did not want this to cause any delay to the re-opening of the ward.

Refurbishing Beaulieu Ward
Throughout the temporary closure of Beaulieu Ward, we used this time to review our services to patients with dementia and worked with system partners to redesign services that are appropriate for the future across Southampton and Hampshire. This is also supported by the Trust's new Dementia Strategy.

By refurbishing Beaulieu Ward, we have been able to improve the environment for our patients by making the ward dementia-friendly.

An overview of changes made to the ward:

- New dementia friendly flooring that has very low reflection and will therefore help to reduce falls and trips
- New furniture in all the rooms
- New staff room, meeting room, and family room to meet CQC requirements and national standards
- The soft room has now been fully refurbished and made into two bedrooms
- The patients will benefit from being single-sex compliant with the creation of a male and female area to maintain privacy and dignity for our patients
- New dementia-friendly furniture and activity equipment throughout
- New therapy equipment for art, music, exercise and much more. Equipment was also bought using a £500 donation from a patient's family
- A robust recruitment plan put in place to ensure we can maintain safe staffing levels on the ward (more details below)

- To adhere to national regulations and become dementia friendly and single sex compliant, significant changes needed to be made to Beaulieu Ward's physical environment. As a result the ward now has 14 beds available to support older people with mental health needs. Previously there were 17 beds.

Please note, we have been carefully monitoring the availability of older people's mental health beds across Hampshire and, despite the temporarily closure of Beaulieu Ward, there has been a surplus of beds. We therefore have a high level of confidence that a small reduction in beds at Beaulieu Ward will not impact our ability to meet demand for hospital beds and will help us to focus on the patients residing on the ward that require one-to-one specialist care.

Staffing on Beaulieu Ward
All staff had a one-to-one meeting with senior managers and HR representatives to discuss available placements and any individual requirements whilst Beaulieu Ward was closed. Following this, all staff were allocated to appropriate placements as agreed with them. The staffing numbers shift by shift for Berrywood Ward were temporarily increased to allow for the fact that the ward, as an Older Person's Mental Health (OPMH) ward, stands alone at the Western Community Hospital (WCH). The increase in staffing numbers enabled a substantial number of Health Care Support Workers to remain at the WCH.

The registered nurses on Beaulieu Ward transferred temporarily to Berrywood Ward. A small number of staff elected to develop their skills within other services for the duration of the closure. These include the Specialist Falls Team and secure mental health services.

Recruitment/staffing update for Beaulieu Ward
Using the recruitment processes, outlined below, we are delighted to inform you that we have recruited new staff to work on the ward both registered nurses and Health Care Support Workers. We are now confident we have the correct level and skill mix of nurses and other health care professionals to safely staff Beaulieu Ward from 3 June 2019.

We are communicating with our staff including a weekly/fortnightly newsletter updating them on progress. Staff have attended a number of training sessions, away days and induction that will support them to work on Beaulieu Ward.

Patients on Beaulieu Ward
All patients and their families were fully informed both verbally and in writing by senior staff of the plan to temporarily close Beaulieu Ward on Friday 16 November. Patients requiring ongoing inpatient treatment were transferred to Poppy and Elmwood wards. Patients requiring an appropriate discharge destination were identified and, with support from Adult Services and the CCG, these were safely discharged. On Friday the 16 November, two patients remained on the ward who were transferred to Berrywood Ward. Both patients were then safely discharged. The staff that transferred to Berrywood from Beaulieu Ward had been able to support these patients to ensure continuity of care.

Since the temporary closure of Beaulieu Ward, eighteen patients have required admission to our inpatient service on either Poppy Ward or Elmwood Ward. We have continued to collate and monitor this to ensure all patients and their families have been supported. We continue to consider alternatives to admission, including care home placement and additional support in the community.

For those patients requiring admission to either Poppy Ward or Elmwood Ward, we speak to individual families to offer support to cover additional transport needs they may have in order to visit loved ones.

As part of whole system working, we continue to focus on effective and safe discharge planning and have initiatives in place to support this process.

Re-admitting patients onto the ward
Any re-admissions onto Beaulieu Ward will be a gradual process and will be focused around the needs of our patients.

In the coming weeks prior to re-opening Beaulieu Ward, we will be looking at those patients on Poppy Ward and Elmwood Ward who could be repatriated to Beaulieu Ward if clinically appropriate and the patient and family are in agreement. Any new patients will be assessed and admitted onto Beaulieu Ward if it's the best possible place for them to receive the care they need.

Recruitment/Staffing Update across our OPMH services
Our Recruitment Specialist has supported the development of a recruitment plan to focus on staffing Beaulieu Ward to enable re-opening; and there will be a continued focus also to recruit to other vacancies across OPMH Services.

Recruitment events took place on the 28 January 2019 and the 5 February 2019.

A social media recruitment campaign is being supported by our Communications Team that includes Snapchat, Instagram, Twitter and Facebook. The campaign will work on showing the engagement and diversity of working within OPMH Services.

Workforce development plans have been formulated and an OPMH Workforce Strategy will be ratified shortly to reflect the skill mix required on the ward and across OPMH. We are working to develop new career pathways and roles and a new care model for OPMH. This has included visiting other services in the country to learn about their successful models of care. This aims to deliver more effective care and make working in this service a more attractive proposition for clinicians. The OPMH Service Manager is attending a student nurse focus group event on the 17 May 2019 to explore with students what it is they look for when applying for posts. It is hoped that this insight might help us further with our recruitment plans.

A continued focus will remain on OPMH staff attending University recruitment events.

Official opening
We have a dedicated communications plan in place to help publicise the re-opening of Beaulieu Ward. Once patients have been admitted onto the ward and are settled, we will be inviting all our key stakeholders (including Local MPs, HASC, HOSP, staff and the families and carers of the patients on the ward) for an official opening event (**Date to be confirmed).**

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Southern Health
NHS Foundation Trust

04 2019
Communications and Engagement Team

Briefing note:
Planned Changes to West Hampshire Learning Disability Service

Overview

For a number of years we have experienced enduring logistical problems in regard to the location of our West Hampshire Learning Disability team. This impacts on the level of care we are able to provide and so, after engagement with staff and patients, we are proposing to move services from Totton Hub (in Totton) and Hampshire House (in Eastleigh) to Tatchbury Mount (in Calmore) this May/June.

We believe this will improve the quality of care we can deliver and also staff efficiency - and we have the support of both patients and staff to do this.

Background

Southern Health staff have worked from these two offices owned by Hampshire County Council (HCC) for a number of years and have experienced IT connectivity issues throughout this time, as well as some other logistical issues linked to the premises.

This results in a number of problems:

- Inability to connect to an IT service (and complete patient notes in a timely fashion).
- IT service 'dropping out' whilst in use, resulting in a loss of data and having to re-input the information (wasting precious clinical time).
- Difficulty with printing important patient documents, letters etc.
- Compatibility issues with keyboards (and the cost to replace these) plus the need to switch keyboards when using RiO cards to access clinical notes (depending on the task required).
- Accessibility issues for staff, visitors and patients trying to access the council building at Totton Hub - resulting in service users missing appointments because they cannot park and service users feeling unsafe or anxious while crossing busy roads.
- A reduction in available space for the learning disability team across both sites - Hampshire House in particular. This reduces the space for our learning disability staff to host students, hold storage, access desks with appropriate IT on them etc.

These problems have been outstanding for several years and there have been long and protracted communications with HCC and their IT team about the problems, which have not resulted in any satisfactory or permanent solutions due to system set up and access issues. As a result, due to the increasing impact on our staff and patients, we needed to consider a more radical solution to solve the problems - a solution suggested by staff themselves.

Planned Changes

The proposal is to relocate the learning disability team members currently based at Totton Hub and Hampshire House to Tatchbury Mount. The benefits include:

- IT connectivity at Tatchbury is reliable and the system is protected and supported by Southern Health's own IT services, which are responsive and allow for easy fix solutions.
- Access to the building will be easier for staff, visitors and patients – admin staff will meet and greet service users/visitors and direct them to the waiting area, all on the ground floor.
- Parking on the Tatchbury Mount site is free and, where appropriate, spaces for Blue Badge Holders will be controlled to ensure availability.
- Having one team in one base would allow for greater team cohesion, improved team communications and more streamlined administration processes, giving clinical staff more time with patients – this is something that the whole team would welcome.
- Treatment rooms and meeting rooms are easily accessible to all.

Naturally there are some risks associated with this proposed change of base - namely the increase in staff, patient and carer travel. There is also the potential that our relationships with some of our HCC colleagues, whom staff currently work closely with, may diminish to some extent. However, these risks are mitigated by the following points:

- Since June last year, there has been an organic reduction in certain services provided at Totton Hub and Hampshire House anyway, due to new HCC teams moving into the buildings. As a result, an increasing number of home visits have been organised, due to the lack of available office space. This will continue to be carefully monitored following the move, but we believe that having access to our own treatment and clinic rooms will help clinicians provide a reliable service and we can be more proactive in ensuring access for service users.
- This is further mitigated by home visits when a patient's circumstances or their clinical presentation requires this. Indeed, the majority of our patients are seen in their own environments.
- We will provide staff with a 'change of base' allowance to cover any additional costs related to increases in their daily mileage when the move happens.
- Travel to the northern area of our team's service boundary has already been supported as we have a drop-in facility at Beech Hurst in Andover and we plan to keep this to support effective working in that area.
- HCC colleagues have moved to a 'Hub model', changing their geographical boundaries so they no longer match our health boundaries. As part of this, access to immediate social care support now goes through a single point of access rather than the local social care teams - and therefore our staff are no longer working with colleagues in the same building as was happening previously. There are arrangements in place to maintain the close working relationships and communication between health and social care which were put in place when this change occurred and remain in place.

Meeting the Trust's values

The Trust believes the proposal to relocate some of our West Hampshire Community Learning Disability Team would reflect the Trust's values.

<u>Patients and People First</u>
Access to Tatchbury is easier for patients and more welcoming, with experienced Learning Disability team members personally welcoming all into the building. Parking is close to the building with clearly marked areas for disabled parking. The rooms to be used are all on one floor with easy access for all visitors. The management of room bookings would be via the learning disability team exclusively, allowing for flexibility of booking and room availability.

Partnership
We will continue to work closely with our social care colleagues and senior HCC and Southern Health management have been meeting to promote ways of working.

Members of the Service User Group which currently meets at Totton Hub have been involved in planning the move to Tatchbury and many already are familiar with the site (as part of the service was based there a few years ago) and so they have welcomed the move.

Partnerships within the team will be strengthened by virtue of being based on one site, and this single base will also support more staff being able to attend team meetings and events. Being located together will strengthen team resilience during difficult periods and will further enhance team working and cooperation.

Respect
The work we have undertaken to engage key partners in this planned change of base demonstrates the respect we have for the people we serve and the team members who deliver the care. We are also mindful that to get the very best from our resources, pooling them all in one location will aid the care we give and the wellbeing of our staff.

When?

It is planned that the move will take place in late May or early June 2019.

Engagement Activity & Next Steps

Our staff have been frustrated by some of the aspects of working in HCC building and recognise this is unlikely to change. The frustrations and clinical time wasted at the current locations mean that staff have pushed for this move, in order to improve working conditions and ultimately the care they provide to patients. As a result, the workforce has been kept informed of the proposed move throughout the planning process and have been very positive regarding this.

The involvement and engagement of staff has helped us identify the specific issues with Totton Hub and Hampshire House, which have been raised via Trust reporting systems, in personal supervision sessions, via emails as well as in team meeting forums. They have had opportunity to challenge the proposed move but to date this has not been the case and we have had full and committed engagement from our staff.

Patient voices have been heard and listened to regularly through our Service User Groups, which meet every six weeks. They have also been instrumental in developing an accessible letter to be shared with all service users regarding the move.

We have also listened to individual service users who have voiced to clinicians that they have found Totton Hub difficult to access, due to poor parking and busy roads. At Hampshire House, service users have found their appointments sometimes need rebooking due to changes in room use or changes by HCC staff when prioritising meetings. Service users, carers and families find this difficult to manage as they have made special preparations for these visits and find it difficult to change without notice.

The listening and sharing of information will continue until the proposed move date. Once the move has been completed, service users, carers and families will be asked to feedback with regard to any changes which will make access even better for them. To date, service users have been supportive of the plans to move staff from Totton Hub and Hampshire House to Tatchbury Mount.

Any questions?

If you have any questions, please contact Margaret Martins, Team Manager, West Hampshire Community Learning Disability Team on 023 80 383444 or email: margaret.martins2@southernhealth.nhs.uk.

Ends

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	14 May 2019
Title:	Integrated Intermediate Care
Report From:	Director of Adults' Health and Care

Contact name: Debbie Butler

Tel: 01962 847226 **Email:** Debbiebutler2@nhs.net

Purpose of this Report

1. The purpose of this report is to provide the Health and Adult Social Care Select Committee with the background and the latest position with regard to the creation of an integrated Intermediate Care service to operate across the whole of Hampshire. This proposed service will bring together elements of Hampshire County Council directly provided services and Southern Health NHS Foundation Trust to support Hampshire residents to avoid unnecessary hospital admissions and to be supported to leave hospital settings in a timely manner and return to independent living.

Recommendation(s)

2. For the Health and Adult Social Care Select Committee to note and support the project approach and the direction of travel in seeking to create an integrated health and social care service.
3. To note the managerial, service and legal options available in creating an integrated health and social care and endorse the preferred route to organisational alignment and integration.
4. For the Health and Adult Social Care Select Committee to receive a further update in October 2019.

Executive Summary

5. This report sets out the ambition to achieve a Hampshire County Council and Southern Health NHS Foundation Trust re-designed, jointly led and integrated health and social care crisis response, rehabilitation and reablement service for the whole of Hampshire. This integrated service was a recommendation following the Care Quality Commission (CQC) Local System Review in Hampshire. This service development is a key component of the action plan this Committee and the Health and Wellbeing Board have previously endorsed and received updates upon.

6. The vision of this project, and in due course the new service, is to achieve significant benefits across the whole system including:

   - An improved client experience that is person-centred, seamless and integrated;
   - A clear and effective pathway for individuals to promote recovery and independence;
   - Improved efficiency by reducing service duplication and increasing productivity;
   - Rationalising spend across the health and social care system;
   - Minimising future demand for health and care services by reducing avoidable hospital admission rates, reducing length of hospital stay and reducing reportable and non-reportable hospital delays;
   - To enable people to retain their independence and remain in their homes for as long possible, thereby minimising the need for ongoing complex packages of care.

7. Hampshire Clinical Commissioning Groups (CCGs) and Hampshire County Council have developed and agreed a shared specification for a Hampshire integrated Intermediate Care service. The specification sets out the requirements for rehabilitation, reablement and recovery services to prevent unnecessary hospital admission and promote individuals fullest possible recovery following an episode of ill-health, including ensuring timely discharge from hospital. The service is to be made up of crisis response and standard services through a single point of access and, whilst Intermediate Care will normally take place in peoples' own homes (or the place they normally call home), there will be a provision for people who require a period of bed based Intermediate Care.

8. The primary providers of current services, Hampshire County Council and Southern Health Foundation Trust, have worked together to develop a Proposal for an integrated service which meets the requirements of the specification. The Proposal has been met with support by system leaders and agreed in principle, subject to the delivery of a satisfactory implementation plan and agreement through the respective governance of all commissioning and provider organisations.

The Integrated Intermediate Care Service (IIC)

9. The requirement is for a Hampshire wide service which provides all people with equity of access to Intermediate Care, although it is acknowledged that different localities and Integrated Care Systems (ICS) will have varying needs dependent on geography and demographics. For this reason, precise pathways, processes and structures may vary slightly in order to accommodate local needs.

10. The proposed service model will bring together current Hampshire County Council and Southern Health Foundation Trust crisis response, rehabilitation and reablement functions under a single management structure. It is proposed that a management team is jointly appointed to manage service

implementation and delivery. At this time it is not proposed that other staff should be jointly appointed but rather a Section 75 agreement be put in place to enable managers to direct the work of staff from the other organisation. This will not change the employer or the current terms and conditions of staff.

11. It is proposed that there will be one Local Access Point (LAP) for each ICS (two in the North and Mid system until suitable accommodation can be identified), to manage referrals and allocate work to teams. In-reach activity, largely from acute providers, will also be coordinated from the LAPs.

12. Rehabilitation and reablement beds will be reviewed, rationalised and reconfigured to ensure that all IIC beds are of a standard and configuration to meet the requirements of the specification irrespective of ownership. This will help achieve more capacity in the system, thereby reducing delays in acutes and communities, whilst delivering a cost effective bed offer which ensures that people are able to access appropriate Intermediate Care beds as close to their home as possible.

13. Community home based Intermediate Care services will be redesigned, with a single Hampshire County Council /Southern Health Foundation Trust combined workforce which is able to operate at local level, minimising travel and delays. The teams will interface with Primary Care Network Multi-Disciplinary Teams to ensure effective transitioning.

14. Urgent community response is a key component of an effective IIC service and a new process is to be put in place within the LAPs to ensure that hospital admissions can be avoided wherever possible and ongoing needs are minimised. The LAP will stratify IIC requests with a separate process for Urgent Community Response. Features of the Urgent Community Response service include:

    - Urgent Community Response process will avoid non-elective admissions into acute hospitals from both the community and front door;
    - Referrals can be made by clinicians and professionals in the community and acute settings;
    - As part of the development of Standard Operating Procedures, clear criteria for what constitutes the need and expectation for Urgent Community Response will be developed;
    - The service will operate from 07:00 to 20:00, 7 days a week;
    - Urgent Community Response will take place within 2 hours during service hours;
    - Referrals will be made by a phone call into the IIC LAP, through a designated number;
    - Referrals will be made by clinician/professional to clinician/professional to assess and agree suitability and need;
    - An IIC First Contact Responder will undertake an initial visit to the individual to assess safety and IIC need;
    - Depending on the referral and need, work with the individual may commence immediately and may be for a relatively short period in order to improve an individual’s condition;
    - Therapists will commence work with individuals within 3 days;

- A person may undertake their IIC recovery at home or in an IIC bed depending on individual needs and circumstances and this will be determined as part of the referral process.

15. In order to develop, test and improve the different aspects of the new operating model, a forerunner programme has been in place for a number of months. Forerunners currently in train include integrating Hampshire County Council and Southern Health Foundation Trust care staff, integrating Hampshire County Council and Southern Health Foundation Trust Occupational Therapy staff, developing the Winchester Triage Hub (a future Local Access Point) and developing a frailty admission avoidance model. The next phase of forerunners has now commenced, and areas being developed and tested include: Local Access Points in each of the localities; working practice and operational structures with Primary Care Networks; and Acute hospital in-reach services.

Finance

16. The redesigned and integrated Intermediate Care service is intended to provide the following benefits:

- Yield economies of scale;
- Stabilised workforce through improved recruitment and retention and increased workforce flexibility;
- Increased productivity;
- Improved service resilience;
- Positive impact on health and care systems by enabling people to remain in good health in their own homes for longer.

17. It is the intention not to increase the current funding envelope for Intermediate Care. However, if there is a case of enhancing services beyond the specified requirements which clearly demonstrate beneficial impacts, an appropriate business case will be submitted for consideration as part of the normal financial planning process.

18. Work will be undertaken with commissioners to determine the best mechanism for funding the future integrated service. However, the current mechanism of the Better Care Fund (BCF) provides a way of both accounting for the money and also to report on elements of current (individual) service performance. The BCF is currently subject to a review at a national level and whatever amendments or replacement may be recommended to the BCF, development of a ‘pooled fund’ for this service will require an additional Section 75 agreement to be put in place.

Performance

19. Performance measures and Key Performance Indicators are to be developed in line with national best practice developed by Social Care Institute for Excellence (SCIE). The aim will be to have a set of simple measures, qualitative and quantitative measures to support effective operational

management of the service. These measures will be described in the presentation accompanying this paper.

Consultation and Equalities

20. Staff engagement and consultation will take throughout the process and formal consultation will take place if necessary, although this has yet to be determined.

21. An Equality Impact Assessment will be undertaken at the next stage of decision making and subsequent implementation.

Conclusions

22. Many areas across the country already have the equivalent of integrated Intermediate Care services in place. A huge amount of energy and organisational determination, both for commissioners and providers, is being directed into this project in Hampshire.

23. In line with the findings of the CQC Local System Review, as well as other insights, our collective resources to better support people to live independently and to avoid unnecessary hospital admission and / or return to their usual place of residence with the maximum opportunity for independent living can be best achieved through this approach.

24. This Committee is asked to note and support the work being undertaken and to receive a further update later in this calendar year in order to seek the creation of a single integrated Intermediate Care service for the residents of Hampshire.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	No

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

Staff engagement and consultation will take throughout the process and formal consultation will take place if necessary, although this has yet to be determined.

An Equality Impact Assessment will be undertaken at the next stage of decision making and subsequent implementation.

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	14 May 2019
Title:	A Strategy for the Health and Wellbeing of Hampshire 2019–2024 - update
Report From:	Graham Allen

Contact name: Kate Jones

Tel: 01962 845195 **Email:** kate.jones@hants.gov.uk

Purpose of this Report

1. The purpose of this report is to update the Select Committee on progress with the development of the Hampshire Health and Wellbeing Board's new strategy, *A Strategy for the Health and Wellbeing of Hampshire 2019–2024*, and the business plan which will support its delivery.

Recommendations

2. That the Health and Adult Social Care Select Committee:
   - Notes the high-level strategy document provided at Appendix A which has been signed off by the Chairman of the Health and Wellbeing Board
   - Considers the Health and Wellbeing Board's business plan for 2019/2020 at a future Select Committee meeting, once the plan has been agreed by the Board
   - Requests an annual update from the Health and Wellbeing Board to report on progress with delivering the Strategy

Executive Summary

3. The Health and Wellbeing Board is required to publish a strategy setting out its vision and priorities for improving the health and wellbeing of the local population. Over the last year, the Board has been developing the approach and high-level content for a new five-year strategy. The new strategy builds on the previous strategy, but has a stronger focus on prevention, tackling inequalities, system leadership and improving mental health in all age groups. A new theme has also been introduced, called 'Dying Well', which will be focusing attention on supporting people of all ages to live well to the end of their life.

4. Engagement on a draft strategy took place over the course of January and February 2019. It was very helpful for the Board to receive a diverse range of feedback from interested and clearly well informed individuals and organisations on the draft strategy. The Board was provided with a summary of the feedback received, and discussed this at its meeting on 14 March 2019, where the high level strategy was approved by the Board.

5. A business plan is now being created for 2019/2020, to outline how the Board will oversee progress each year on delivering the priorities set out in the strategy. Each area in the business plan is being sponsored by a member of the Health and Wellbeing Board. The actions in the business plan will be jointly agreed with partners, with leads assigned, to ensure accountability. A set of performance measures is also being developed, to monitor progress on delivery of the strategy's priorities over the next five years. The Board will be considering a draft business plan at its next meeting on 27 June 2019.

6. The Health and Wellbeing Board recognises that the Health and Adult Social Care Select Committee will be interested in reviewing the Board's progress on improving health and wellbeing across Hampshire. The Board would therefore like to share the final business plan in due course with the Select Committee, and thereafter would be happy to provide a regular progress update on the delivery of the Strategy, as set out in the annual business plan. An annual update for the Select Committee is suggested.

Finance

7. The priorities set out in the Health and Wellbeing Board's strategy will be delivered using the capacity and financial resources of the wide range of partner organisations and groups across Hampshire who support the health and wellbeing agenda. The Board is able to call on a very limited budget, where a minimal investment is required to facilitate engagement or to kick start a new piece of work.

Performance

8. As outlined above, alongside the Health and Wellbeing Board's business plan, a set of performance measures is being developed which will be reported to the Board. This will enable the Board to be clear on existing performance on the priority areas in the strategy and to monitor progress towards meeting the ambitions in the strategy.

Engagement and Equalities

9. The audience for engagement on the draft strategy was organisations on the Health and Wellbeing Board, including the County Council, district and borough councils, the NHS, other public, voluntary and community sector partners and more widely individuals and groups with an interest in the health and wellbeing agenda in Hampshire. The draft strategy was circulated to all Board Members, with a request that they disseminate it within their own organisations and encourage feedback. It was also circulated to all County Councillors and Directors, as well as to a number of other staff and to key external stakeholder organisations. It was published on the County Council's website, with an invitation for people to submit feedback, either by filling in a short online survey or by emailing comments to the Board.

10. A summary of the feedback received during engagement on the draft strategy was presented to the Health and Wellbeing Board on 14 March 2019. A link to the summary of feedback is provided at the end of this report. Overall, the feedback received did not suggest the need to substantially change the high level strategy and its overarching priorities. However, respondents provided helpful insights and suggestions which are assisting in developing the content of the business plan and the performance metrics.

11. The *Strategy for the Health and Wellbeing of Hampshire* is very much an overview document, informed by Hampshire's Joint Strategic Needs Assessment as well as a wide range of work programmes and strategies that are being delivered across Hampshire. A key principle of the strategy is to tackle inequalities, and to focus on reducing the significant difference between those with the best and worst health in Hampshire. It is proposed that an Equalities Impact Assessment will be prepared alongside the Board's new business plan, since this will have more specific areas of activity that can be assessed for the impact on people with protected characteristics.

Conclusions

12. The publication of a new strategy and the creation of a formal business plan, with performance measures, will enable the Health and Wellbeing Board to monitor progress in a more systematic way in the future. It is intended that the business plan will provide a mechanism for the Board to continue to develop its system leadership role and strengthen partnership working across Hampshire.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	yes
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
Report to the Health and Wellbeing Board, 14 March 2019 on a Strategy for the Health and Wellbeing of Hampshire	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

As outlined above, it is proposed that an Equalities Impact Assessment will be prepared alongside the Health and Wellbeing Board's new business plan.

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A Strategy for the Health and Wellbeing of Hampshire

2019–2024

Working together for a healthier Hampshire

Foreword

It is my pleasure to introduce this Strategy for the Health and Wellbeing of Hampshire, on behalf of the Hampshire Health and Wellbeing Board. As a Board, we are all deeply committed to the work that we and our organisations do to improve the health and wellbeing of the people we serve. We all want Hampshire residents to live long, healthy and happy lives with the greatest possible independence.

Hampshire is a great place and generally our population is healthy with good life expectancy. However, outcomes are not as good for some people as they could be. A key feature of this strategy is our ambition to continue to narrow the gap between those with the best and worst health and wellbeing. This means paying attention to the wider determinants of health, such as housing, education, employment, community safety, and the physical environment just as much as we do to traditional health and care services.

This second Strategy contains many of the themes that appeared in our first Strategy. However, I welcome the increased emphasis we intend to place on prevention and on mental health issues. I am also very supportive of the intention to look right across the life course, through the introduction of a new theme, which we are calling 'Dying Well'. This new theme is about living well to the end of life, at whatever age this occurs.

We are publishing this Strategy at a time of great change at national and local level and as a Board we will have to adapt our approach and activities to respond to new developments as they occur. We have tried to align our high-level plans with the recently published NHS Long Term Plan and are aware of Government Green Papers expected in the coming months, on Prevention and on Adult Social Care which will also be highly relevant to the work of the Health and Wellbeing Board.

I would like to thank those individuals and organisations who took the time to read our draft Strategy and who gave us feedback. Inevitably, there were a range of different comments on the content and the way we have presented the issues. As a Board, we have tried to take a balanced approach in deciding the final content. The document that follows gives a broad sense of our purpose and direction for the next five years. We will now work together on a more detailed plan to ensure we make good progress on delivering our ambitions.

Councillor Liz Fairhurst

Chairman of the Hampshire Health and Wellbeing Board
and Executive Member for Adult Social Care and Health at Hampshire County Council

Contents

Introduction

Hampshire's Health and Wellbeing Board brings together partners from local government, the NHS, other public services, and the voluntary and community sector. The Board aims to ensure that organisations plan and work together to improve the health and wellbeing of Hampshire residents. It is only by working together that we[1] can make a big difference to outcomes for all our residents.

This Strategy document sets out the Board's vision and key priorities for the next five years. It looks at long-term goals and key priorities for improvement across a number of themes. We have started to develop the content of a draft business plan setting out delivery priorities for the first year of the new Strategy in 2019/2020, with performance measures. The business plan will be separately agreed by the Board each year following agreement of the Strategy itself.

Our vision

The Health and Wellbeing Board's vision is to enable people in Hampshire to live long, healthy and happy lives, with the greatest possible independence. We want to tackle health inequalities – narrowing the gap in life expectancy and improving healthy life expectancy. In simple terms, we want to ensure that those living longer are also healthier for longer. Making best use of the limited resources we have, we want to improve outcomes and resilience for people of all ages. We want children to have the best possible start in life. We also want people to have choice, control and dignity at all stages of life, including at the end of life.

We will do this by:

- Promoting wellbeing and preventing ill health
- Focusing on reducing the significant difference between those with the best and worst health in Hampshire
- Aiming to create an environment that makes it easier for people to take responsibility for their own health and wellbeing
- Continuing to prioritise the safeguarding of children and vulnerable adults, since feeling safe is an essential starting point for people's wellbeing
- Improving services so they deliver good, accessible and joined-up care
- Championing coproduction and engagement so that the voice of the public, patients, service users and their families – current and future – is better reflected in the design and delivery of health and social care

[1] References to 'we' in this Strategy refer to the members of the ***Hampshire Health and Wellbeing Board***

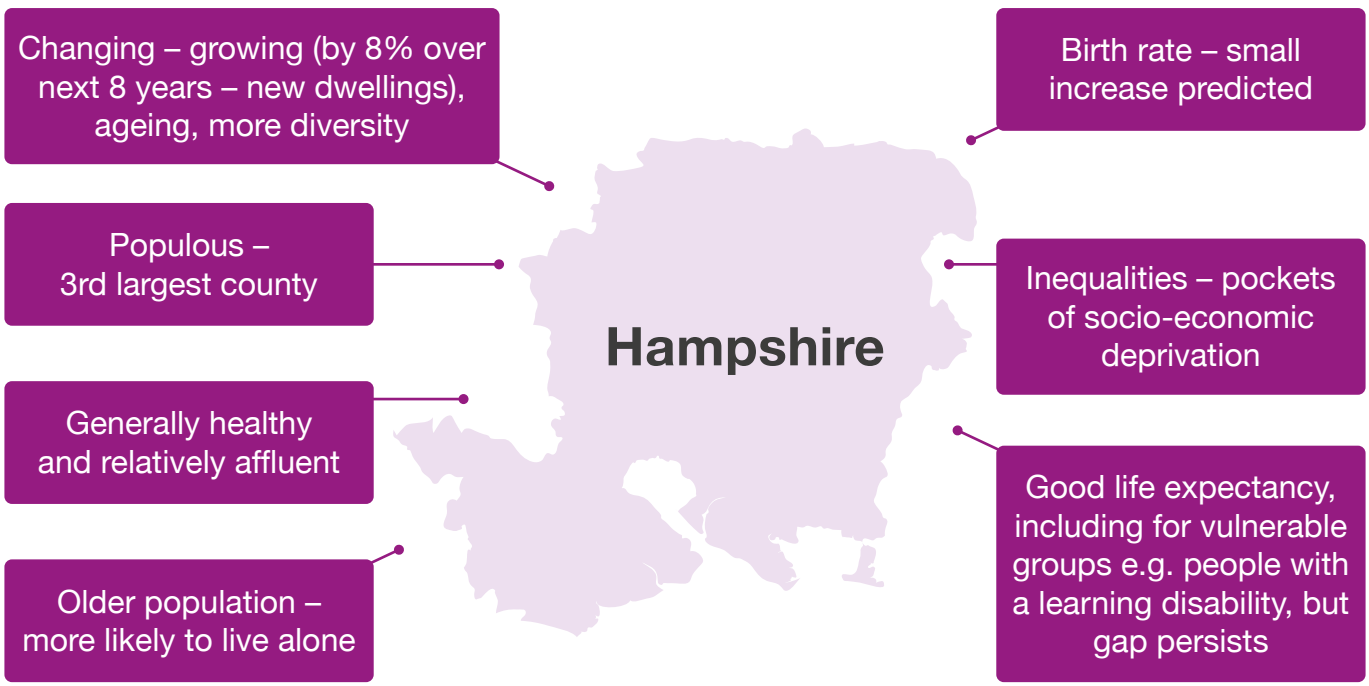
- Using local networks, knowledge and partnerships to ensure services and activities are joined up and respond to what communities need
- Working with partners to deliver the Strategy, including collaborating with neighbouring Health and Wellbeing Board areas so that we align our activities or take a shared approach where this makes sense
- Putting together a plan each year, with milestones, to communicate what areas the Health and Wellbeing Board will focus on to help deliver this Strategy

What do we already know?

Hampshire's **Joint Strategic Needs Assessment** (JSNA) is the primary source of information, as it looks at the current and future health and wellbeing needs within our Hampshire population. The priorities and challenges covered in this Strategy are informed by the JSNA.

As outlined in the JSNA, overall Hampshire is a prosperous county. However, there are health inequalities between areas. Parts of Eastleigh, New Forest, Test Valley, Havant, Rushmoor and Gosport rank among the most deprived 20% of areas in England. The population is changing, getting older and becoming more diverse. The proportion of the population who are 85 years and over is expected to increase by almost 30% by 2023.

In Hampshire, life expectancy at birth for both men and women is better than the England average and is increasing. However, there is a gap between life expectancy and healthy life expectancy. Men spend 14 years and women spend 16 years of their life in poor health.

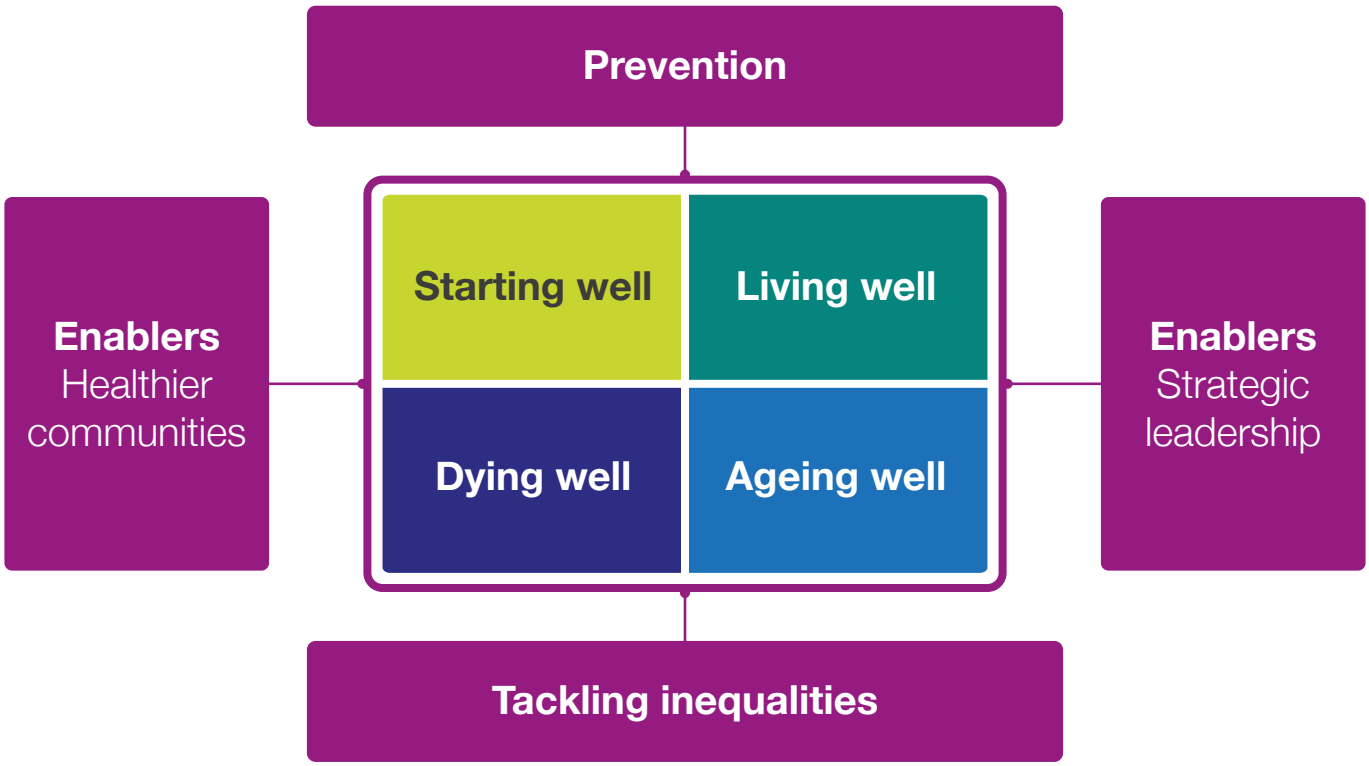


A second source of information that underpins the priorities and activities described in the Strategy is feedback from residents and users of services. Organisations involved in the Health and Wellbeing Board regularly carry out consultation, engagement and coproduction to develop and improve services. This feedback has been incorporated into the priorities and will inform the Board's areas of activity.

A third source of information and intelligence comes from the Board members and individuals in partner organisations who have helped to shape the Strategy through workshops and discussions and contributed towards the drafting process.

The Health and Wellbeing Board's first Strategy, published in 2013, involved significant public engagement as the Board was new and needed to understand the views and ambitions of Hampshire residents to set the direction for its work. For this second Strategy, the Board aims to build on the good work that has already taken place.

We have identified four key priority areas, in addition to two 'enabling' priority areas which span the whole Strategy. Prioritising prevention and tackling inequalities will also be golden threads running through all areas of the Strategy.



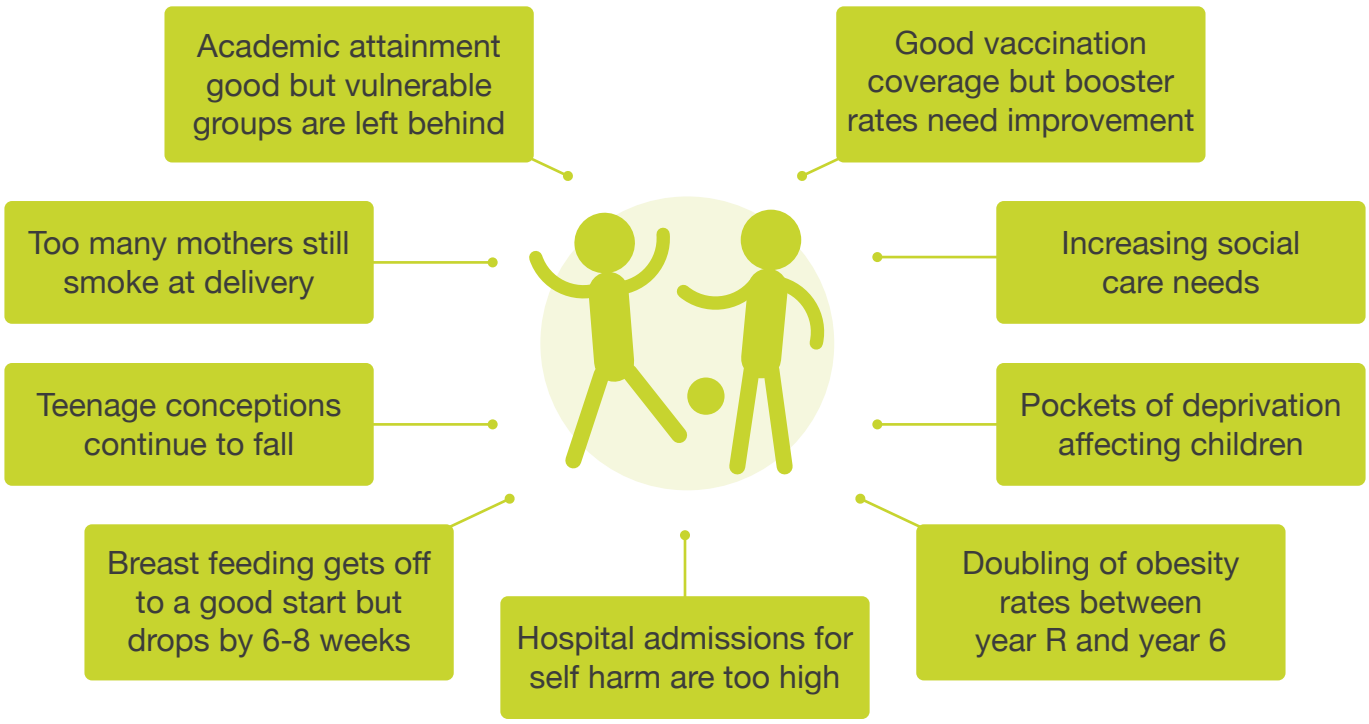
We are looking at new ways of implementing and monitoring this new Strategy. We want to make sure it stays fit for purpose over its five-year duration. To help make this happen, the Board is keen to have a much more focused business plan for each year of the Strategy, so that Board members and the public can see what key activities the Board intends to do, monitor and observe each year. The Board will also measure its success using a number of performance indicators to review progress in each of the priority areas in the Strategy.

Starting well

How are we doing in Hampshire?

There are just over 322,000 children and young people in Hampshire aged 0–19. This represents 21% of the county's population. The number of 0–19s is projected to increase by 4.8% in the next 5 years.

Generally Hampshire's children have good health and good life chances. They are more likely to attend school regularly and be immunised against infectious diseases. The main causes of concern are increasing obesity, emotional wellbeing and mental health, educational attainment in disadvantaged groups, including those children with Special Educational Needs and Disabilities (SEND) and insufficient levels of physical activity.



Where do we want to be in five years' time?

We want to improve the health, happiness and achievement of children and young people, including those who are vulnerable or disadvantaged, such as children with special educational needs or disabilities or looked after children. We will do this by working to reduce inequalities and improving outcomes through greater collaboration. We are committed to early help for children, young people and their families, identifying as early as possible whether a child or family need support, helping them to access services, and working together to ensure this has maximum impact. We will develop service models with service users, children and young people, using family-centred and strength-based approaches, not a deficit-based approach. We will 'Think Family' so that we work in a holistic way that does not just focus on a child or young person in isolation.

Key priorities for improvement

- Improve mental health and emotional resilience for children and young people and their families. This will prioritise prevention and earlier intervention, for example through more support in schools and the wider community, to improve mental health at an earlier stage. There will be a particular focus on vulnerable groups, including those experiencing Adverse Childhood Events, the mental health of parents including perinatal mental health, and emotional resilience in educational settings.

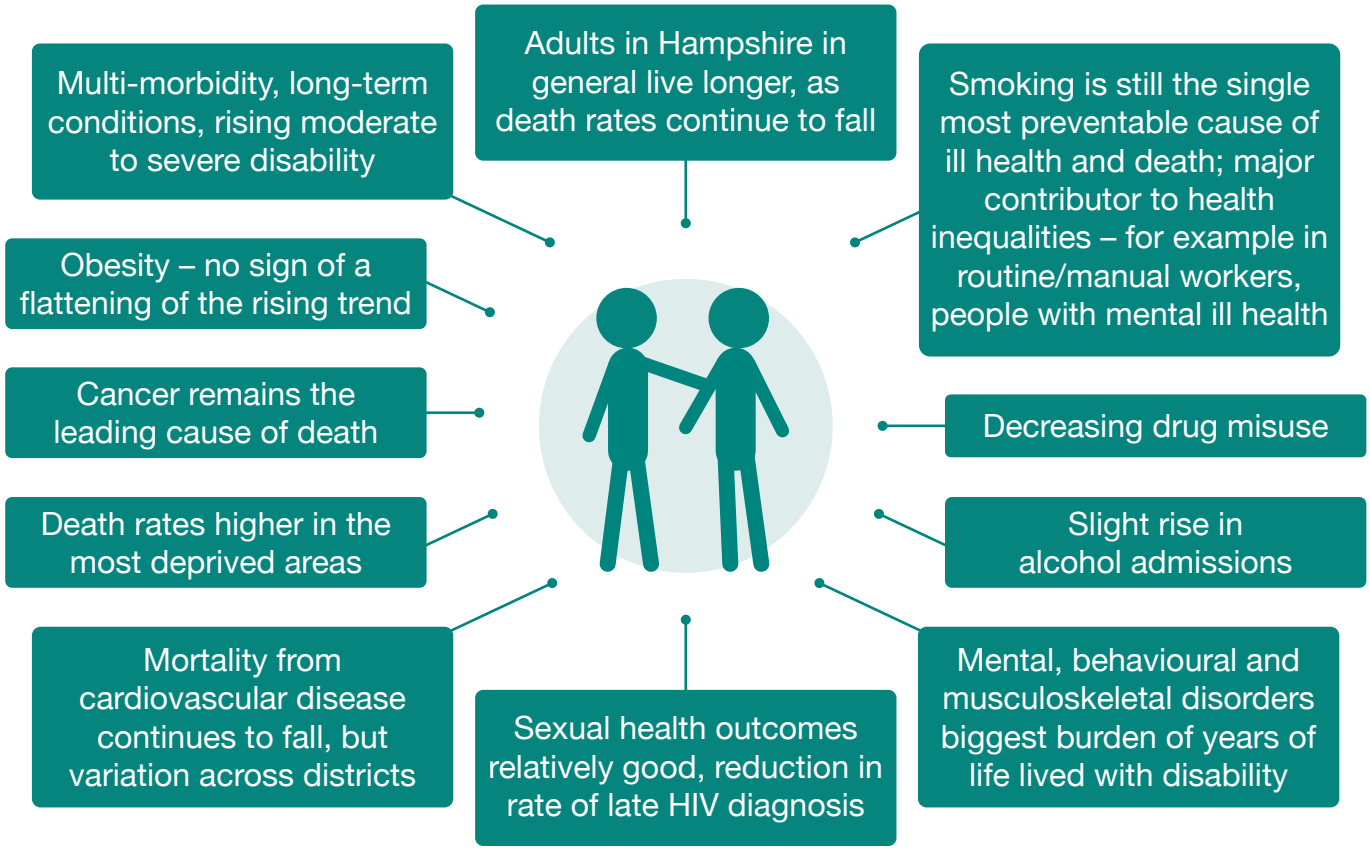
- Improve physical health in children and young people through prevention and early intervention. This will prioritise healthy weights, physical activity and reducing smoking in pregnancy.

- Work more collaboratively across organisations, disciplines and with children and young people and their families to improve outcomes and services, including integrated or aligned approaches where appropriate.

Living well

How are we doing in Hampshire?

There are just over 1.07 million adults aged 18 and over in Hampshire. This represents 79% of the total population. Hampshire has an older population compared to England with a higher proportion of the population aged 45 years and over and fewer young working aged people (aged 20–39). The proportion of residents with a limiting long-term illness or disability is comparable to England. However, the size of the Hampshire population means that the absolute numbers of people experiencing ill health or disability are large.



Where do we want to be in five years' time?

We want to reduce preventable ill-health. We will do this through concerted action on the risk factors we know contribute most to disease. We want to accelerate the reductions in people smoking, especially in our more deprived communities. We want to have a clear understanding of mental wellbeing in our communities and how we can influence it. We want to maximise the life opportunities of people living with health conditions and disabilities. We will encourage self-help and self-management for long-term conditions.

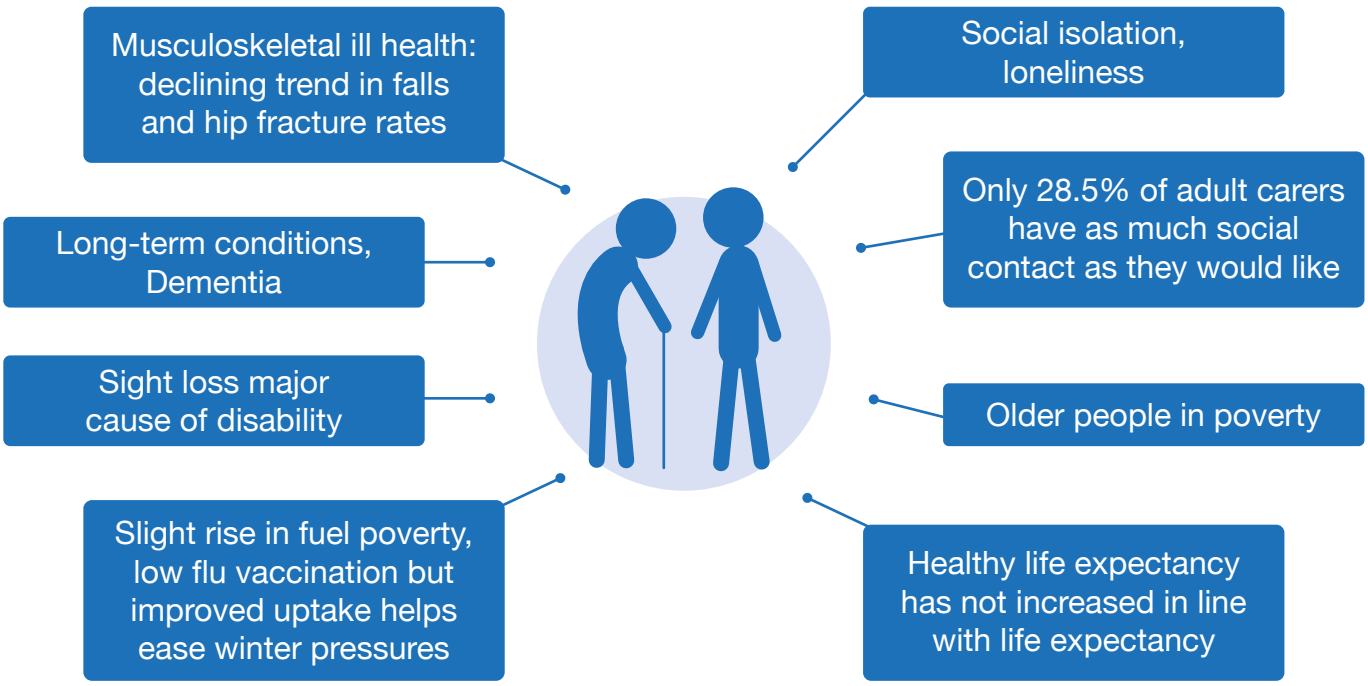
Key priorities for improvement

- Work together to enable people to live healthier lives focusing on the main lifestyle risk factors for cancer, circulatory disease and long-term conditions. We will start with smoking, obesity and physical inactivity.
- Improve the population's mental wellbeing and reduce mental ill-health.
- Enable people with long-term conditions to live healthier lives for longer and reduce variation in outcomes.

Ageing well

How are we doing in Hampshire?

Across Hampshire, just over 1 in 5 people are 65 years and over compared to nearly 1 in 6 nationally. The population of people over 65 in Hampshire is projected to increase to over 333,000 people by 2023. People in Hampshire are enjoying longer lives than ever before, but not all these extra years are lived in good health. Long-term conditions, dementia, musculoskeletal problems and social isolation are more common in older age and can significantly affect the wellbeing of our older population.



Where do we want to be in five years' time?

We want residents to be able to live their later years in a way that helps them to feel healthy, connected and purposeful. This means living in places that enable social connections, offering opportunities to take part in meaningful activity and being surrounded by people who offer support and value the contribution of older people.

Key priorities for improvement

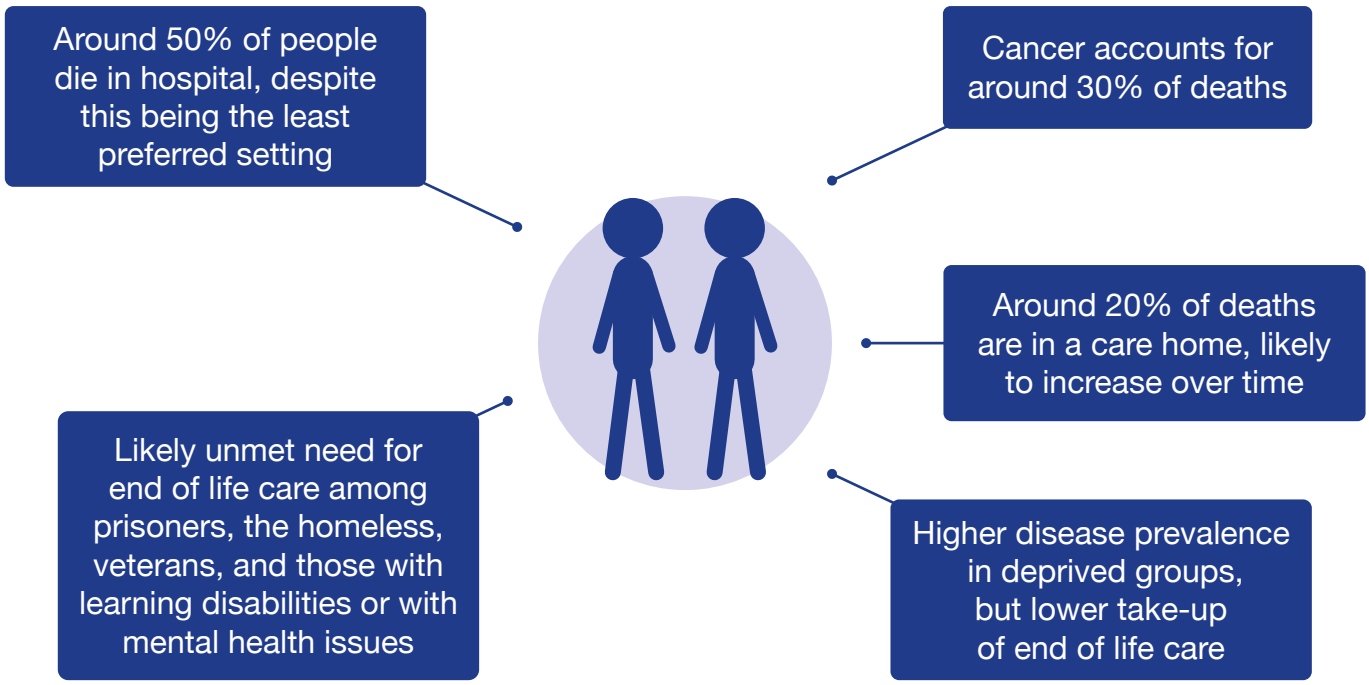
- Continue to develop connected communities which can support people to live happy, healthy lives in the place of their choosing.
- Enable people to plan for a fulfilling, purposeful older age.
- Create healthy home environments which allow people to stay well and independent into older age.
- Enable older people to lead healthy, active lives.

Dying well

How are we doing in Hampshire?

During 2017, 12,973 residents of Hampshire died. One third of deaths were due to cancer. 27% of all deaths were premature (under 75 years): almost half of these were due to cancer and nearly one fifth were circulatory diseases. Almost 10% of all deaths had mental and behavioural disorders as the underlying cause of death, the huge majority of which were from dementia. Amongst other long-term conditions, dementia is an important chronic condition for which palliative care is needed because unlike other long-term conditions there is a shorter window of opportunity to have meaningful conversations with people about their wishes for the end of their life.

Whilst child deaths are rare, in Hampshire 92 child deaths were notified to the Child Death Overview Panel in 2017/18. Over two-thirds (67%) of child deaths reviewed in Hampshire were of children under the age of one.



Where do we want to be in five years' time?

We want to move to a situation where people of all ages have a good life up to the end of their life, supported to live well with life-limiting conditions. Individuals and their carers will have timely, honest and well informed conversations about dying, death and bereavement. Their preferences and wishes will be known and recorded in advance to ensure clear communication with all involved in providing care and support at end of life. Parents, family, friends and other loved ones will be supported with preparing for loss, grief, bereavement and potential loneliness. This support will

continue after the death of the person. More people will be enabled to die well in a place of their choosing, receiving equitable end of life/palliative care irrespective of their primary diagnosis.

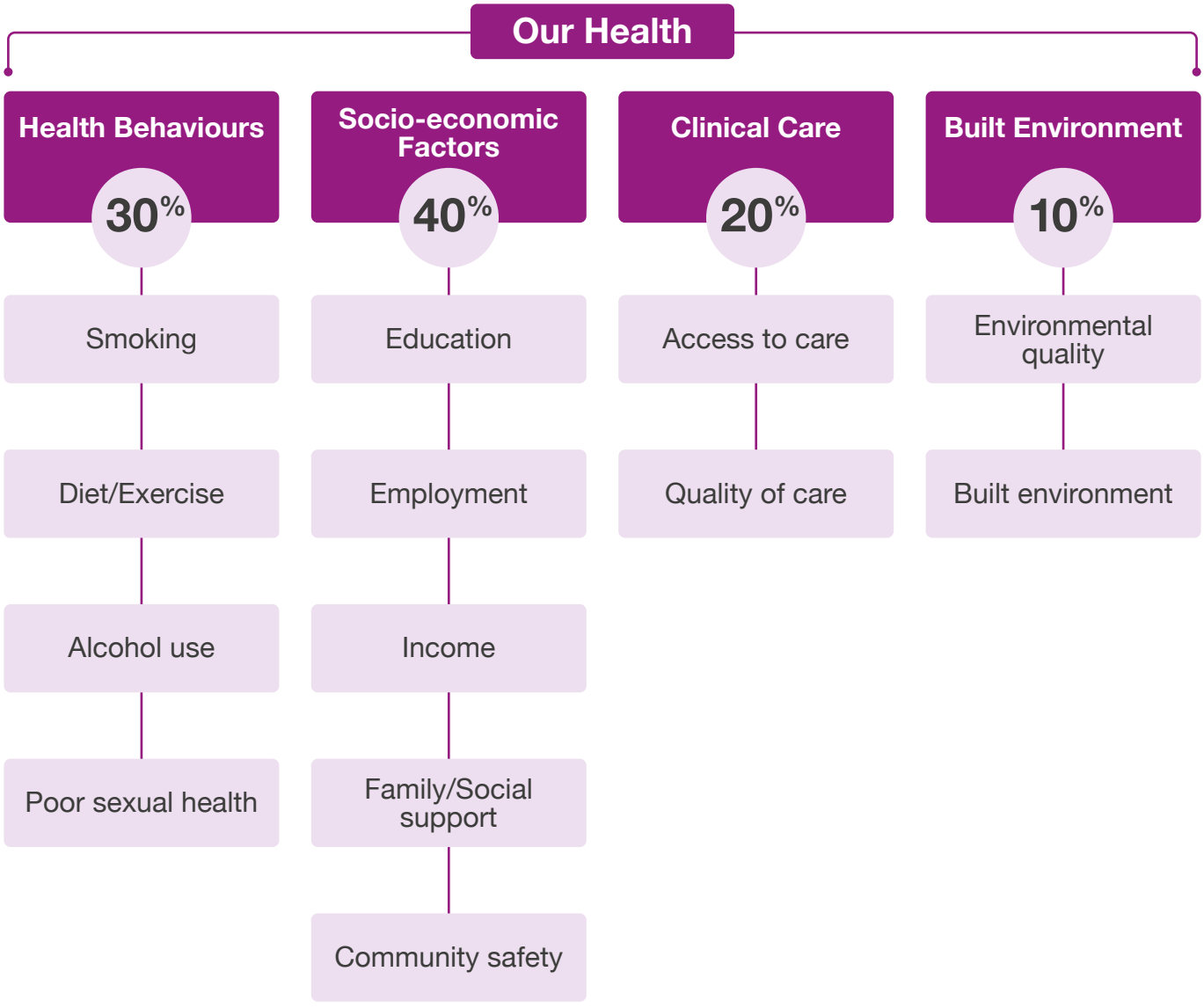
Care will be well integrated and coordinated, between the NHS, specialist palliative care, hospice services, social care and the voluntary sector. There will be transparency about the role each organisation plays so that it is clear to everyone, including the person at end of life, their family and support networks.

Key priorities for improvement

- Ensure person-centred care, choice and control is consistently in place across Hampshire to help people live well with life-limiting conditions.
- Support people at end of life to return to or remain in their preferred setting in the last days and hours of life.
- Improve skills and capacity across Hampshire to ensure people are encouraged and supported to have early and timely conversations about end of life wishes and choices. This will help individuals and their families to plan and prepare in advance.
- Work together effectively across organisations to provide well integrated care and consistent palliative care, building on a shared care plan irrespective of organisational or funding boundaries.
- Improve access to bereavement support and services locally, for all age groups, especially for parents, families and educational communities following the death of a child, for children experiencing the loss of a parent, and for long-term carers who may also need support when their caring role ceases.

Healthier communities

Many factors contribute to our health and wellbeing and only about half of these factors are related to health behaviours and clinical care as illustrated below. The type of housing and neighbourhood we live in, how connected we are with family, friends and our local community, how much money we have, whether we have a job, the lifestyle we follow, and whether we can access transport, leisure and other facilities all play a part.



To achieve the ambitions in this Strategy to improve the health of the whole population, and particularly to address health inequalities and the prevention agenda, we recognise that all partners will need to work together to address wider social and economic determinants of health, starting by:

- Advocating for health and wellbeing priorities to be reflected in all local policies
- Supporting communities to be strong and connected to reduce loneliness and isolation

- Ensuring neighbourhoods are well designed to help people make healthy choices
- Advocating for more affordable and well-designed housing that can meet individuals' varying needs; promoting accessible design in housing; tackling homelessness
- Education and skill development from early years through schools and into adulthood
- Tackling poverty where possible, and helping people to access jobs
- Promoting sustainable, accessible transport and active travel
- Improving access to green spaces (such as parks and other open spaces), blue spaces (such as canals, ponds, rivers and beaches) and other leisure facilities
- Recognising the negative impact of climate change on our residents' health: seeking ways in which the Board can contribute to climate change mitigation and the adaptation of services to take account of our changing climate
- Improving air quality

The County Council, district and borough councils and the community and voluntary sector are well placed to influence the above factors but NHS partners also have a central role to play.

Local level organisations are particularly well placed to identify trigger points for crisis and to implement interventions that divert or prevent people's needs from escalating. They also have invaluable knowledge that can be better utilised to inform commissioning. There is a recognition however that resources are diminishing, so we need to join up support and target resources better, seeking to reduce duplication of effort and spend.

Strategic leadership – how we can join up the system better across Hampshire

Hampshire is a large county, with a complex range of services in the public, private, voluntary and community sectors. A crucial part of the Health and Wellbeing Board's role is to join up the system better, promoting positive culture change for the benefit of our residents, and adding value to the collective delivery arrangements of all the different organisations involved in health and wellbeing.

We want to see transformational improvement across the whole system, so that wherever you live in Hampshire, you can expect consistent outcomes when you interact with services and organisations that support health and wellbeing.

The Board will use a population health approach to inform this work, and over the next five years will oversee a number of 'enabling' workstreams to help join up and improve the health and wellbeing of the population. Progress on these workstreams will be reported regularly to the Board. These key enablers are listed below:

1 Deliver care closer to home

Outcome:
To support people at the right time, in the right place, and with the right services, so that fewer people are unnecessarily admitted to hospital or delayed there once they are ready to leave, and they can access suitable services after being in hospital to help them recover

2 Harness the potential of digital solutions

Outcome:
To give people the opportunity to take control of their information and to enable organisations to work together better to deliver seamless care

3 Support a sustainable workforce of paid staff and support unpaid carers and volunteers

Outcome:
To create the conditions where individuals receive sufficient support from the right people – whether paid or unpaid – who have the knowledge, training and motivation required for their roles

4 Consistent and accessible information and advice

Outcome:
To enable people to take control and access the information they need

5 Improve health and wellbeing for people in organisations on the Health and Wellbeing Board

Outcome:
People in our organisations feel supported to be healthy and can help others

6 Champion coproduction and engagement in service design

Outcome:
Services meet the needs of residents better, because they reflect the voice of those who will use them

7 Make better shared use of our buildings and community resources

Outcome:
We use our reducing resources wisely to provide joined-up services that are easy to access

Alternative formats and further information

To request a copy of this Strategy in another format such as large print, audio or Braille, or for any queries about the Board's work, please contact Hampshire's Health and Wellbeing Board at: **hampshirehwb@hants.gov.uk**

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	14 May 2019
Report Title:	Work Programme
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 845018 **Email:** members.services@hants.gov.uk

Purpose of Report

1. To consider the Committee's forthcoming work programme.

Recommendation

2. That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE: 2019

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.*							
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies	Living Well Healthier Communities	Hampshire Hospitals NHS FT and West CCG	Update last heard April 2019 Next update to be considered Nov 2019, inc UTC developments (invite West CCG to joint present with HHFT)			
Dorset Clinical Services review **(SC)**	Dorset CCG are leading a Clinical Services review across the County which is likely to impact on the population of Hampshire crossing the border to access services.	Starting Well Living Well Ageing Well Healthier Communities	Dorset CCG / West Hampshire CCG	First Joint HOSC meeting held July 2015, CCG delayed consultation until 2016. Last meeting August 2017 to consider consultation outcomes. Decision made by CCG in line with Option B 20 September, which HASC supports.	Verbal update to be received once next meeting has been held. **(M)**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
North and Mid Hampshire clinical services review **(SC)**	Management of change and emerging pattern of services across sites	Starting Well Living Well Ageing Well Healthier Communities	HHFT / West Hants CCG / North Hants CCG / NHS England	Monitoring proposals for future of hospital services in north and mid Hampshire since Jan 14. Status: last update Jan 2019. Retain on work prog for update if any changes proposed in future. Timing to be kept under review.			
Move of patients to Eastleigh & Romsey Community Mental Health Team	Patients in Eastleigh southern parishes historically under Southampton East Team moving to Eastleigh and Romsey team	Living Well Ageing Well	Southern Health	Briefing note presented at Sept 18 meeting. Supported as not SC. Update received April 2019. Further update requested when transfer complete (timing tbc)			
Spinal Surgery Service	Move of spinal surgery from PHT to UHS (from single clinician to team)	Living Well Ageing Well	PHT and Hampshire CCGs	Proposals considered July 2018. Determined not SC. Update on engagement received Sept 2018. Implementation	Update		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
				update requested for May 2019.			
Chase Community Hospital	Hampshire Hospitals NHS FT - Outpatient and X-ray services: Reprovision of services from alternative locations or by an alternative provider	Living Well Ageing Well	HHFT and Hampshire CCGs	Item considered at May 2018 meeting. Sept 2018 decision is substantial change, further update Nov 2018 meeting. Latest update Feb 2019 (health hub developments update due later in year, when CCG has reviewed options. Pencil in for July meeting)		Update (tbc)	
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*							
Temporary Closure OPMH Ward	Southern Health NHS FT – reported in Oct temporary closure to admissions to Poppy and Beaulieu wards.	Living Well Ageing Well	Southern Health NHS FT	Last Update received at Jan 2019 meeting. Beaulieu temp closed for up to 6 months. Requested further update May 2019.	Update due (M)		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
Care Quality Commission inspections of NHS Trusts serving the population of Hampshire	To hear the final reports of the CQC, and any recommended actions for monitoring.	Starting Well Living Well Ageing Well Healthier Communities	Care Quality Commission	To await notification on inspection and contribute as necessary. PHT last report received Sept 2018, update heard April 2019. Requested paper update July 2019 and attendance Nov 2019. Focused Inspection of ED update provided May 2019. SHFT – latest full report received Nov 18. Update received April 2019, requested further update with paper for July 2019. HHFT latest report received Nov 18. Paper update received Feb 2019. Requested update for May 2019. Solent – latest full report received April	PHT ED inspection **(M)** HHFT Update **(M)**	PHT update **(E)** SHFT update **(M)**	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
				2019, requested update on minor improvement areas for Nov 2019 (could be paper only) Frimley Health NHS FT inspection report published 13 March 2019, scheduled for July 2019 UHS FT being inspected Spring 2019. Timing for report to HASC tbc, poss July		Frimley report UHS report (tbc)	
CQC Local System Review of Hampshire	To monitor the response of the system to the findings of the CQC local system review, published June 2018.	Ageing Well Healthier Communities	AHC at HCC	Latest update received in April 2019 on 6 month milestones. Next update due July 2019 on 12 month milestones (including CCG rep to jointly present)		Update due (M)	
Sustainability and Transformation Plans: one for	To subject to ongoing scrutiny the strategic plans covering the	Starting Well Living Well	STPs	H&IOW initially considered Jan 17 and monitored July 17 and 18, Frimley			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
Hampshire & IOW, other for Frimley	Hampshire area	Ageing Well Healthier Communities		March 17. System reform proposals Nov 2018. STP working group to undertake detailed scrutiny – updates to be considered through this. Update from working group verbally April 2019.			
Overview / Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*							
Budget	To consider the revenue and capital programme budgets for the Adults' Health and Care dept	Starting Well Living Well Ageing Well Healthier Communities	HCC Adults' Health and Care (Adult Services and Public Health)	Considered annually in advance of Council in February (next due Jan 2020) Transformation savings pre-scrutiny alternate years at Sept meeting. T21 due Sept 2019.			T21 budget pre scrutiny
Orchard Close	To consider proposals to close Orchard Close Respite Service, Hayling	Living Well Ageing Well	HCC Adults' Health and Care	Workshop held 4 Dec 2018. Pre scrutinised at additional Feb 2019 HASC prior to Feb EM decision.			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
	Island			Call In meeting 14 March 2019 recommended EM re-consider. EM re-considered 29 March and confirmed to undertake further work prior to decision in Nov. April 2019 Working Group agreed, to meet to consider options and feed back to Nov 2019 meeting.			
Integrated Intermediate Care	To consider the proposals relating to IIC prior to decision by the Executive Member	Living Well Ageing Well	HCC AHC	To receive initial briefing on IIC May 2019, with pre-scrutiny of EM Decision due later in the year (tbc)	Briefing		
Scrutiny Review - *to scrutinise priority areas agreed by the Committee.*							
STP scrutiny	To form a working group reviewing the STPs for Hampshire	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations	ToR agreed September 2017. Met Dec 2017, March 2018, Sept 2018, Dec 2018. Further	Verbal updates to be received when appropriate		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
				meetings to be held in 2019 as required.			
Real-time Scrutiny - *to scrutinise light-touch items agreed by the Committee, through working groups or items at formal meetings.*							
Adult Safeguarding	Regular performance monitoring of adult safeguarding in Hampshire	Living Well Healthier Communities	Hampshire County Council Adult Services	For an annual update to come before the Committee. Last update Nov 2018, next due Nov 2019			
Public Health	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Substance misuse transformation update heard May 2018. 0-19 Nursing Procurement pre scrutiny Jan 2019 Hampshire Suicide audit and prevention strategy due May 2019	Suicide item		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	14 May 2019	9 July 2019	16 September 2019
Health and Wellbeing Board	To scrutinise the work of the Board	Starting Well Living Well Ageing Well Healthier Communities	HCC AHC	Joint Health and Wellbeing Strategy refresh agreed by Board March 2019. To receive item on this May 2019, to then inform future scrutiny of performance against the strategy	JHWS		

Key

(E) Written update to be received electronically by the HASC.
(M) Verbal / written update to be heard at a formal meeting of the HASC.
(SC) Agreed to be a substantial change by the HASC.

Other requests not yet scheduled:

Sept 2018: CAMHS assessments of children in schools and change in provider
Gosport Independent Review - overview of response of system partners tbc
NHS 10 Year Plan – overview of what this sets out and how this is being taken forward locally tbc

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.